Lovett Family Chiropractic & Wellness Center Personal Injury

Please provide the front desk with a photo ID & most current insurance card.

Name: _____ **Nickname:** _____ Today's Date:_____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Social Security#:_____ Marital: M S W D Birth Date:_____ Age:_____

Occupation: _____ Employer: _____

Home #:_____ Cell #:_____ Ok to contact you via text: YES NO

E-Mail: _____ Ok to E-mail LFC Newsletter to you: YES NO

*Your information (including e-mail address & phone number will never be shared with anyone)

Spouse: _____ Phone#:_____

How many children? _____ Names and Ages of Children:_____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Who referred you to our office? _____

Family Medical Doctor: _____ Phone: _____

May we update your medical doctor regarding your care at this office? YES NO

Who is ultimately responsible for this account? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

Have you been treated for any health condition by a physician in the last year? YES NO

If yes, describe: _____

What **medications or drugs** are you taking? Date started/stopped and dosage. Prescribed by: Dr or Self

_____

_____

What **Vitamins or Supplements** are you taking? Date started/stopped and dosage. Prescribed by: Dr or Self

_____

Do you have any allergies of any kind? YES NO If yes, describe: _____

_____

Please list any other health problems you have, no matter how insignificant they may be: _____

_____

_____

FAMILY HISTORY

Father: Living ____ Deceased ____ Current age if still living: _____ Cause of death and age at death if deceased: _____

Mother: Living ____ Deceased ____ Current age if still living: _____ Cause of death and age at death if deceased: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother, **C**hildren):

_____Neck Pain _____Back Pain _____Headaches _____Neuropathy

_____Tuberculosis	_____Cancer	_____Mental Illness	_____Lung Disease
_____Diabetes	_____Asthma	_____Heart Disease	_____Kidney Disease
_____Stroke	_____Arthritis	_____Liver Disease	_____Other _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

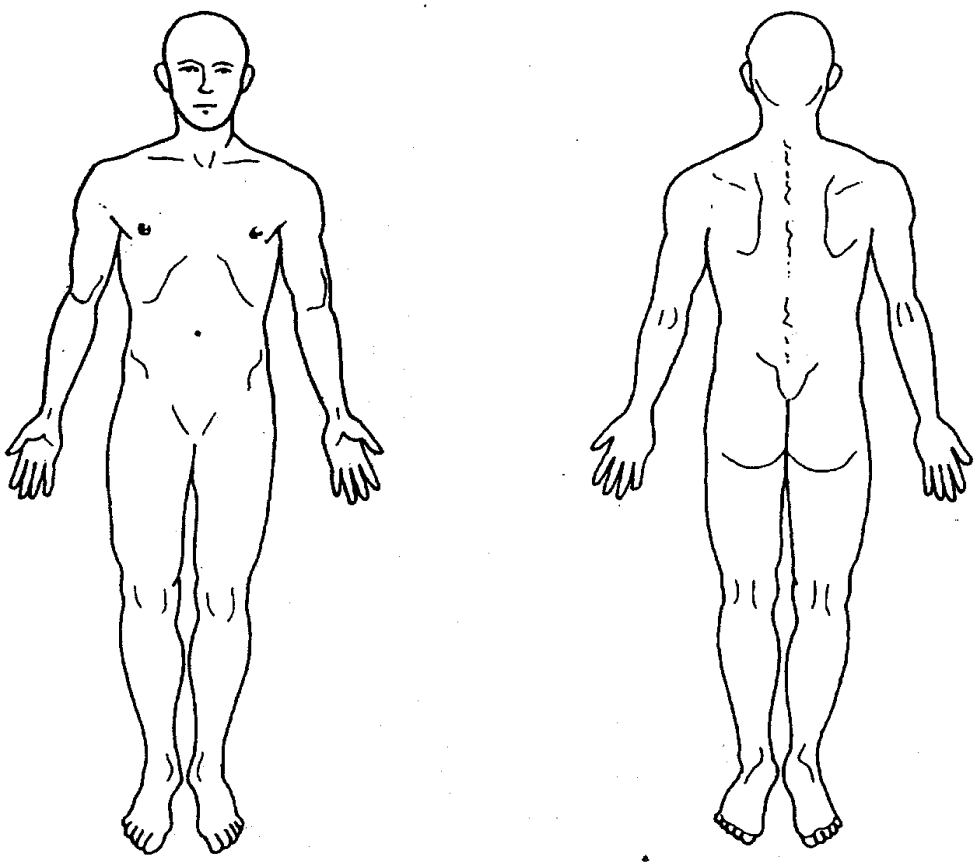
Patient/Guardian Signature: _____ Date: _____

TELL US WHERE YOU HURT.

Mark the areas on your body where you feel your pain. Include all affected areas.

Ache = A Numbness = N Pins & Needles = P

Burning = B Stabbing = S Throbbing = T



SYMPTOMS

Patient's Name_____ Date of incident _____Today's Date_____

CIRCLE ALL YOU COMPLIANTS

1. DO YOU HAVE LACERATIONS, CUTS OR BRUISING? :
   a. Head or Face
   b. Neck
   c. Seat belt bruising
   d. Cuts or bruising on your chest
   e. Cuts or bruising on arms
   f. Cuts or bruising on legs
   g. Other: _____

2. HEAD INJURIES: (now or at the time of the accident)
   a. Were you knocked out or unconscious
   b. Headaches
   c. Face pain
   d. Pupils different sizes
   e. Dizziness
   f. Difficulty walking
   g. Balance problems
   h. Room spins
   i. Disoriented Confusion
   j. Day dreaming
   k. Attention problems
   l. Hearing problems
   m. Change in sense of smell or taste
   n. Difficulty speaking
   o. Memory problems
   p. Very tired or fatigued
   q. Appetite change
   r. Sleep difficulties
   s. Visual Disturbances, blurry or double vision
   t. Flashbacks to accident
   u. Problems to read or write
   v. Problems adding or subtracting
   w. Problems learning new things
   x. Problems understanding
   y. Problems remembering numbers
   z. Difficulty Concentrating
   aa. Difficulty remembering things
   bb. Difficulty making decisions
   cc. Change in Sexual Functioning
   dd. Nausea / Vomiting
   ee. Change of personality
   ff. Wanting to be alone
   gg. Mood swings
   hh. Sadness
   ii. Agitation
   jj. Anger
   kk. Helplessness
   ll. Reduce confidence
   mm. Apathy
   nn. Irritability
   oo. Sleepiness
   pp. Frustration
   qq. Impatience
   rr. Other head related issues

   _____

3. JAW PROBLEMS:
   a. Jaw pain
   b. Clicking
   c. Pain while chewing
   d. Pain while talking
   e. Pain while yawning
   f. Pain while moving jaw from side to side

4. NECK INJURIES:
   a. Neck pain
   b. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
   c. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
   d. Neck pain, numbness, tingling, weakness that radiates or goes down to RIGHT UPPER BACK
   e. Neck pain, numbness, tingling, weakness that radiates or goes down to LEFT UPPER BACK
   f. Neck pain that causes headaches
   g. Neck spasms or shoulder spasms
   h. Popping, clicking or clunking sound with neck movement

5. SHOULDER INJURIES
   a. Shoulder pain LEFT RIGHT BOTH
   b. Shoulder pain with movement L R BOTH

c. Shoulder spasms LEFT RIGHT BOTH
d. Sharp shoulder pain
e. Dull shoulder pain
f. Achy shoulder pain
g. Pins and needles shoulder pain
h. Shoulder pain that radiates or shoots pain into arm
i. Other:

_____

6. UPPER ARM PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

7. ELBOW PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

8. FOREARM: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

9. WRIST PAIN: RIGHT LEFT BOTH
   a. Dull
   b. Ache
   c. Sharp
   d. Stabbing
   e. Other

_____

10. HAND PAIN: RIGHT LEFT BOTH
    a. Dull
    b. Ache
    c. Sharp
    d. Stabbing
    e. Other

_____

11. MID BACK PAIN OR UPPER BACK PAIN
    a. Upper or mid back pain
    b. Upper back pain, numbness, tingling, weakness that radiates or goes down to RIGHT shoulder, arm, forearm or hand
    c. Upper back pain, numbness, tingling, weakness that radiates or goes down to LEFT shoulder, arm, forearm or hand
    d. Upper or mid back spasms

12. LOW BACK PAIN:
    a. Low back pain
    b. Low back pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
    c. Low back pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
    d. Low back spasms

13. PELVIC OR SACRAL PAIN
    a. Pelvic pain, numbness, tingling, weakness that radiates or goes down to RIGHT buttock, thigh, leg or foot
    b. Pelvic pain, numbness, tingling, weakness that radiates or goes down to LEFT buttock, thigh, leg or foot
    c. Sacral pain (tail bone)
    d. Coccygeal or coccyx (tail bone) pain

14. HIP PAIN: RIGHT LEFT BOTH
    a. Hip pain
    b. Hip pain, numbness, tingling, weakness that radiates or goes down to buttock, thigh, leg or foot

15. UPPER LEG PAIN: RIGHT LEFT BOTH
    a. Upper leg pain that radiates to knee
    b. Upper leg spasms

16. KNEE PAIN: RIGHT LEFT BOTH
    a. Knee pain that radiates to calf
    b. Knee pain that radiates to calf and ankle

c. Knee pain that radiates to calf, ankle and foot

17. ANKLE PAIN: RIGHT LEFT BOTH
    a. Ankle pain that radiates to foot
    b. Ankle and foot pain
18. FOOT PAIN: RIGHT LEFT BOTH
19. CHEST PAIN
20. STOMACH PAIN
21. OTHER SYMPTOMS:

_____
_____
_____
_____

Informed Consent For Chiropractic Care and Therapies

Chiropractic care, like ALL forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care and therapies include stiffness, soreness, discomfort, skin irritation, sprain/strain injuries, irritation of a disc condition, and very rarely, fractures.

Prior to receiving chiropractic care this Chiropractic office, a thorough health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand that chiropractic adjustments involve the doctor placing his or her hands on me and delivering a very specific, quick thrust or impulse to the involved area(s). Alternatively, the doctor may use an instrument in place of his or her hands. I understand and accept that there are risks and benefits associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments and other therapies, as reported following my assessment.

_____ _____ _____

Printed Name Signature of Patient Date

Informed Consent to X-Rays (Pregnancy Release)

In order for Lovett Family Chiropractic to correctly evaluate, diagnose and treat my condition, x-rays may be needed. X-Rays expose the patient to radiation, similar to the amount of radiation on a Trans-Atlantic flight. Repeated exposure to radiation has been correlated to increase cancer risk. I grant LFC permission to perform x-rays, if needed, and assume all risks and responsibilities from an x-ray procedure.

The radiation in x-rays may be harmful to an unborn child/developing fetus. I understand that there are risks involved in exposing an unborn child to radiation and assume all responsibility for receiving an x-ray procedure. By my signature below, I certify that I am not pregnant at the time of this x-ray procedure.

_____ _____ _____

Printed Name Signature of Patient Date

Pacemaker Release

I hereby certify that I do not have a Pacemaker of Defibrilator of any kind in or on my body. I understand that if I do have one of these devices in or on my body, I will let the doctor know and my treatment may be slightly altered as a result. Pacemakers and Defibrilators are NOT contraindicated with chiropractic care but they ARE contraindicated with cold laser therapy.

_____ _____ _____

Printed Name Signature of Patient Date

Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and / or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Pain Relief Rehab., the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with the Colorado Unfair Claims Practice Act, Revised Statute Section 10-3-1104 to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me / us for treatment rendered by the physician facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician / facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to the Colorado Unfair Claims Practice Act, Revised Statute Section 10-3-1104, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to **Lovett Family Chiropractic**, and to send all checks to 12201 E. Arapahoe Rd, #B-10, Centennial, CO 80112.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable to **Lovett Family Chiropractic**, and to send all checks to 12201 E. Arapahoe Rd, #B-10, Centennial, CO 80112.

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician / facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician / facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician / facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my / our account or forwarded to my / our address upon request in writing to the physician / facility named above.

PATIENT RESPONSIBILITY: I understand and agree that I am 100% directly and fully responsible to said Medical Provider for all medical services rendered and bills issued pursuant to this Contractual Lien:

(a) Even if any insurance company denies payment in whole or part for such medical services;
(b) Even if patient is forced to file a lawsuit due to denial of payments by an insurance claims adjuster; and
(c) Even if a judge or jury renders a verdict in my lawsuit that the insurance company for said person or entity is not responsible for payment for Patient's medical bills.

REJECTION IN WRITING: I hereby authorize the physician / clinic named above to establish a MedPay or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider / clinic named above, any rejections in writing as they apply to my lack of MedPay or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 10-4-635 of the Colorado Revised Statute, and further instruct my carrier to

pay up to available limits directly to physician / clinic named above, and to send any and all checks or financial instruments to 12201 E. Arapahoe Rd, #B-10, Centennial, CO 80112.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he / she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician / facility immediately. I understand that failure to do so may jeopardize my case.

Signature of patient and / or responsible parties:

Patient: _____ Date: _____

Medical Provider: _____ Date: _____

Attorney: _____ Date: _____

AUTO INSURANCE INFORMATION

Your Insurance Company _____ Phone #: _____

Claim #: _____

Other Party's Name: _____

Other Party's Ins. Co._____ Phone #: _____

Claim #: _____

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjustor_____Company_____

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name_____ Phone #: _____

ACCIDENT QUESTIONNAIRE

Patient's Name_____

DESCRIBE YOUR VEHICLE

1. Vehicle Type :
   a. Sports Car
   b. Coupe
   c. Sedan
   d. Sports Utility Vehicle
   e. Station Wagon
   f. Pick-up truck
   g. Bus
   h. Other: _____

Make:_____Year:_____

Model:_____Estimated Speed:_____

2. Vehicle Size:
   a. Compact
   b. Mid-Sized
   c. Full-Sized

DESCRIBE THE ACCIDENT

3. Date of Accident: _____

4. Actions of patient's vehicle:
   a. crossing an intersection
   b. stopped at an intersection
   c. stopped for a pedestrian
   d. stopped for traffic
   e. traveling at posted speed limit
   f. traveling faster than the posted speed limit
   g. turning

5. How was the patient's vehicle hit:
   a. hit head-on
   b. was hit on the left front
   c. was hit on the right front
   d. was hit on the left rear
   e. was hit on the right rear
   f. was rear-ended
   g. Other: _____

6. Damage to patient's vehicle:
   a. complete
   b. extensive
   c. minimal
   d. moderate

7. Describe the second vehicle:
   a. compact
   b. full size
   c. mid size
   d. semi trailer
   e. pick-up truck

Make:_____ Year:_____

Model:_____ Estimated Speed:_____

8. Damage to the other vehicle?
   a. complete
   b. extensive
   c. minimal
   d. moderate

9. Weather Conditions
   a. Clear
   b. Cloudy
   c. Drizzling
   d. Foggy
   e. Rainy
   f. Snowy
   g. Stormy
   h. Sunny

10. Road Conditions
   a. Damp
   b. Dry
   c. Dry with icy patches
   d. Iced over
   e. Snowed over
   f. Wet

DESCRIBE THE MOMENT OF IMPACT

11. Body position at time of impact:
   a. leaning forward
   b. slouched down in seat
   c. straight
   d. turned to the left
   e. turned to the right

12. Direction body was thrown:
   a. backward then forward
   b. forward then backward
   c. to the left
   d. to the right
   e. about the vehicle
   f. outside the vehicle
   g. under the vehicle

13. Head position at impact:
   a. straight
   b. tilted forward
   c. turned to the left
   d. turned to the right

14. Direction head was thrown:
   a. backward then forward
   b. forward then backward
   c. side to side

15. Type of restraint:
   a. lap belt
   b. shoulder belt
   c. shoulder lap belt

16. Place patient was seated in the vehicle:
   a. Driver
   b. front passenger
   c. back passenger driver side
   d. back passenger right side
   e. back passenger middle
   f. other_____

17. Did Airbags deploy:
   a. yes
   b. no

18. Were you seen at a Medical Facility following your accident:
   a. Yes
   b. No
   If so name and address of the facility:

_____
_____

Patient Signature: _____

Table 18-4 Ratings Determining Impairment Associated With Pain

Name:_____ Date:_____

I. Pain (Self-report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

None — Excruciating

D. Rate how much your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Activity does not aggravate pain — Excruciating following any activity

Sum score of Section I: A–D = Total pain severity/4 = _____

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Rarely — All of the time

Add total pain severity score (items A–D/4) to score for item E = _____

Total pain severity score (range from 0 to 20) = _____

II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk 1 block**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to walk — Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent from lifting 10 pounds — Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not restrict ability to sit for 1/2 hour — Impossible to sit for 1/2 hour

D. How much does your pain interfere with your ability to **stand for 1/2 hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Pain does not interfere with ability to stand at all — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not limit activities — Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere with relationships — Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely unable to do any job around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to shower or bathe without help

M. How much does your pain interfere with your ability to **write or type?** (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Does not interfere at all — My pain makes it almost impossible to engage in any sexual activity

P. How much does your pain interfere with your ability to **concentrate**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Never — All the time

Sum score of Section II:
A-P = Total score for activity limitation/16 =
Mean activity limitation = _____

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week. (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10

Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse**?

0 1 2 3 4 5 6 7 8 9 10

Not at all anxious/worried — Extremely anxious/worried

Sum score of Section III:
A-E = Total pain impairment attributed to mood state/5 =
Mean score = _____