Lovett Family Chiropractic & Wellness Center Pediatric Case History/ Patient Information

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

Child's Name: _____ **Nickname:** _____

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

Social Security#:_____ Date of Birth:_____ Age:_____

Mother's Name: _____ Father's Name: _____

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

E-Mail: _____ Ok to contact you via e-mail: YES NO

E-mail is the primary way that we communicate with our patients regarding upcoming appointments.

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

Emergency Contact: _____ Phone #: _____ Relationship: _____

Who referred you to our office? _____

Pediatrician: _____ Phone: _____

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

Reason for seeking examination/care at our office: _____

_____

PAST MEDICAL HISTORY

Has this child ever been diagnosed as having or have suffered from? (Place a check by those that apply)

__Broken or Fractured Bones	__Digestive Problems	__Colic	__Skin Disorders
__Seizures/Convulsions	__Diabetes	__Asthma	__Allergies
__Chronic Ear Infections	__Autism	__ADD/ADHD	__Neck or Back Pain
__Headahces	__Vascular problems	__Chronic Colds	__Recurring Fevers
__A Congenital Disease	__Cancer	__Scoliosis	__Coughing Blood

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? (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: _____

_____

DEVELOPMENTAL MILESTONES

__ mo/yrs Follow and object with eyes __ mo/yrs Hold head up __ mo/yrs Crawl

__ mo/yrs Sit Unaided __ mo/yrs Stand up __ Walk unaided

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: _____

Are there any family members who suffer from the same condition as the child? If so, please list: _____

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 _____

INSURANCE COVERAGE (Please check any and all insurance coverage that may be applicable in this case**)**

____Major Medical ____Medicare ____ Auto Accident ____Worker's Compensation

____Medical Savings Account & Flex Plans ____Other _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

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's Printed Name Parent/Guardian's Name Parent/Guardian Signature Date

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 performs a thorough health history and physical examination on every potential patient. 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.

_____	_____	_____	_____
Patient's Printed Name	Parent/Guardian's Name	Parent/Guardian Signature	Date

Informed Consent to X-Rays

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 small doses of radiation. 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.

_____	_____	_____	_____
Patient's Printed Name	Parent/Guardian's Name	Parent/Guardian Signature	Date

Pacemaker/Defibrilator 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.

_____	_____	_____	_____
Patient's Printed Name	Parent/Guardian's Name	Parent/Guardian Signature	Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____	_____	_____	_____
Patient's Printed Name	Parent/Guardian's Name	Parent/Guardian Signature	Date

For further information regarding this notice, please contact our office at (720) 747-1500.

Lovett Family Chiropractic and Wellness Center
12201 E. Arapahoe Rd.
Centennial, CO 80112
720 747 1500
www.lovettfamilychiro.com

Six Steps to Identifying and Correcting the Cause of Your Problem

1. ***Fact Finding-*** During your initial visit you will take part in a consultation, examination and x-rays if necessary, to figure out exactly what is causing your symptom. (Example: Back pain is not your problem, it is a symptom. We need to figure out the problem that is causing your symptom.)
2. ***Dr. Analyzes the Results-*** In between your initial and second visit, the doctor will take time to review and analyze all of the information that was gathered during your initial visit to come up with the most accurate diagnosis for your condition and the best course of action to address your condition.
3. ***Report of Findings-*** This will take place during your second visit to our office. The doctor will review with you the findings from your consultation, exam and x-rays. At this time the doctor will let you know if your condition is appropriate for chiropractic care or if you need to be referred to another type of care provider. If the doctor determines that your condition is appropriate for chiropractic care, at this time he will recommend a treatment plan necessary to correct your condition.
4. ***Cost of Care Estimate-*** After your Report of Findings, our front desk Chiropractic Assistant will review your personalized cost of care estimate based on your treatment plan. It will include any insurance coverage co-pays and deductibles that the Assistant was able to verify with your insurance company.
5. ***Treatment-*** Your treatment plan will include the essential procedures and modalities to address your specific condition. Nothing less and nothing more. See back of this sheet for more information on the procedures/modalities available at our office.
6. ***How to Stay Young the First 100 Years class-*** This is a riveting class about the beneficial aspects of chiropractic care. All New Patients attend the class once within the first two weeks of beginning care. It is offered in the office every Tuesday at 12:45 and every Wednesday at 6:15. We can couple one of your appointments to match up with the class so that you do not have to make a separate trip. We encourage you to bring family and friends to this informative presentation. The more that they understand what you are going through, the better they will be able to support your recovery.

Explanation of Chiropractic Adjustments and Modalities

Chiropractic Adjustments- Adjustments can be performed by hand or by instrument. They allow the joints of the body to move properly. When the joints move properly it takes pressure off of the nerves which allows the nerves to function properly. These nerves control every cell, tissue and organ in our body. Thus by helping the nerves to function properly, chiropractic adjustments improve the health and function of our entire body, as well as decreasing pain. Chiropractic adjustments are safe and effective for all ages of adults and children.

Massage Therapy- The goal of massage is to use a therapeutic touch to reduce tension, pain and discomfort, and encourage healing, rejuvenation and wellness. Massage uses range of motion to restore flexibility and motion in otherwise restricted joints, as well as to lengthen and stretch individual tissue fibers and muscle groups. Massage also increases circulation to an area to speed up the healing process, as well as relax tight, restrictive muscles to restore mobility, flexibility and full muscle function. Massage supports your chiropractic adjustments and helps you stay aligned longer.

Cold Laser Therapy- Cold Laser Therapy works on a cellular level to decrease pain, decrease inflammation and increase healing. It is called "cold" because it is such a low level of energy that it does not create heat. It helps the mitochondria of the cells to increase the production of ATP (cellular energy) which helps cells to heal faster.

Rehabilitation- Rehab involves active exercises that work to re-train the brain and body to hold your body in proper alignment after your adjustments. Rehab works to strengthen and stabilize your spine and support your adjustments. Rehab should be performed every day at home, just like brushing your teeth, in order to get the best results.

Interferential Therapy- Interferential current therapy is a treatment to aid the relief of pain and the promotion of soft-tissue healing. Tiny electrical impulses are sent into the tissues in the area of the pain. The low-frequency stimulation induces the body to secrete endorphins, which are the body's natural pain-killers. Most patients find interferential therapy to be very beneficial and describe the treatment as being relaxing and having a 'pins and needles' sensation.

Neck Orthotic- The neck orthotic is recommended for patients who have no curve or a reverse curve to their neck. The Neck Orthotic helps to re-establish the proper curve in your neck. Proper curve in the neck is very important for your overall neurological health. You lay on the neck orthotic for 2-15 minutes per day at home. (specific directions are provided)

Kinesio-Tape- Kinesio-tape works to support muscles and joints of the body. Kinesio-tape differs from traditional athletic tape because it is highly flexible, hypo-allergenic, water resistant and can stay on the body for up to seven days. Kinesio-tape can be used for neck pain, back pain, pain in the arms and legs, sprained or strained muscles, swelling and bruising.

ALINE Foot Orthotics- Orthotics support the natural arches of the foot and help to correct pronation and supination of the foot. (rolling in or out on the foot) ALINE Orthotics are unique because we can very accurately measure the degree of pronation or supination and quickly develop a semi-custom orthotic that will correct the biomechanical dysfunction in the foot. Orthotics are great for patients with foot, ankle, knee, hip and even low back problems.

Ionic Foot Bath Detoxification- The ionic foot bath pulls toxins out through the feet by polarizing the water, sort of like a magnet. Toxins often get caught inside of our body, particularly in fatty tissue, and get stuck there. The foot bath polarizes the extracellular matrix of our body to release the toxins so they can be excreted for days afterward. Patients often say they feel more energy, think clearer and feel better after a foot bath.