LOWERY
FAMILY CHIROPRACTIC

DATE:_____

PATIENT INFORMATION

Name: _____
(LAST) (MI) (FIRST)
Address _____
(STREET) (CITY) (STATE) (ZIP)
Home Phone: Work Phone: Cell Phone:

Email Address: _____

DOB: / / Soc. Sec#: - -

Drive's License #: State:

Marital Status: S M W P Spouse's Name:

Employer: Occupation:

Employer Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referred By: _____

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name: _____

Member #: Group #:

Insurer's Name (If Different From Patient): _____

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer: _____

Person responsible for account: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature: **Date:**

_____ _____

LOWERY FAMILY CHIROPRACTIC

Patient Name: _____

IMPORTANT: Please place and X next to all present symptoms:

HEAD
- Headache
  - Sinus (Allergy)
  - Entire Head
  - Back of Head
  - Fore Head
  - Temples
  - Migraine
- Head Feels Heavy
- Loss of Memory
- Light Headedness
- Fainting
- Light Bothers Eyes
- Blurred Vision
- Double Vision
- Loss of Vision
- Loss of Taste
- Loss of Balance
- Dizziness
- Loss of Hearing
- Pain in Ears
- Ringing in Ears
- Bussing in Ears

NECK
- Pain in Neck
- Neck Pain w/Movement
  - Forward (Flexion)
  - Backward (Extension)
  - Turning to Left
  - Turning to Right
  - Bending to Left
  - Bending to Right
- Pinched Nerve in Neck
- Neck Feels Out of Place
- Muscle Spasms in Neck
- Grinding Sounds in Neck
- Popping Sounds in Neck
- Arthritis in Neck

SHOULDER
- Pain in Shoulder Joints (L - R)
- Pain Across Shoulders
- Bursitis (L - R)
- Arthritis (L - R)
- Tension in Shoulders
- Muscle Spasms
- Difficulty Raising Arms (L - R)
  - Above Shoulder
  - Over Head

ARMS & HAND
- Pain in Upper Arm (L - R)
- Pain in Elbow (L - R)
- Tennis Elbow
- Pain in Forearm (L - R)
- Pain in Hand (L - R)
- Pain in Fingers (L - R)
- Pins & Needles Sensation
  - Arms (L - R)
  - Fingers (L - R)

CON'T ARMS & HAND
- Numbness
  - Arms (L - R)
  - Fingers (L - R)
- Finger "Fall Asleep" (L - R)
- Hand Cold (L - R)
- Swollen Joints
  - Hand (L - R)
  - Fingers (L - R)
- Sore Joints
  - Hand (L - R)
  - Wrist (L - R)
  - Fingers (L - R)
- Arthritis (L - R)
- Loss of Grip Strength (L - R)

UPPER/MID BACK
- Mid-Back Pain
- Location _____
- Pain Between Shoulder Blades
- Sharp Stabbing Pain
- Dull Ache
- Pain From Front to Back
- Muscle Spasms
- Pain in Kidney Area

CHEST
- Chest Pain
- Shortness of Breath
- Pain Around Ribs
- Breast Pain
- Dimpled or Orange Peel Breast
- Irregular Heartbeat

ABDOMEN
- Nervous Stomach
- Food Unable to Eat _____
- Nausea
- Gas
- Constipation
- Hemorrhoids

LOW-BACK
- Low Back Pain
  - Upper Lumbar
  - Lower Lumbar
  - Sacroiliac
- Low Back Pain is Worse When:
  - Working
  - Lifting
  - Stooping
  - Standing
  - Sitting
  - Bending
    - Flexion (Forward)
    - Extension (Backward)
    - Lat. Flexion (Sideways)
  - Coughing
  - Lying Down (Sleeping)
  - Walking

CON'T LOW-BACK
- Pain Relieves When_____
- Slipped Disc (Herniated)
- Lower Back Feels Out of Place
- Muscle Spasms
- Arthritis

HIP, LEGS, & FEET
- Pain in Buttocks (L - R)
- Pain in Hip joint (L - R)
- Pain Down Leg (L - R)
- Knee Pain
  - Inside (Medial)
  - Outside (Lateral)
- Leg Cramps (L - R)
- Pins & Needles Sensation
  - Leg (L - R)
  - Feet (L - R)
  - Toes (L - R)
- Numbness
  - Leg (L - R)
  - Feet (L - R)
  - Toes (L - R)
- Feet Feel Cold
- Swollen Ankles

WOMEN ONLY
- Menstrual Pain _____Location
- Cramping
- Irregularity
- Cycle _____ # Days
- Birth Control _____Type
- Hysterectomy
- Genital Cancer
- Discharge
  - Color _____
- Tumors
- Abortions _____#
- Menopause
- Miscarriage _____#

MEN ONLY
- Urinary Frequency _____#
- Difficulty in Starting
- Night Urination _____#
- Prostate Pain/Swelling

GENERAL
- Nervousness
- Irritable
- Depressed
- Fatigue
- Feeling Run Down
- Tea/ Coffee _____ # cups per day
- Cigarettes _____ # packs per day
- Alcohol _____ # drinks per week
- Diabetes
- Hypoglycemia
- # Hours of Sleep _____
- Weight Loss or Weight Gain _____
- Exercise _____times per week

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Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have good understanding with our patients regarding financial responsibility. We hope this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through_____.

- If you have out-of network benefits we will be happy to give you a receipt so you may file.
- You **MUST PAY** any co-payment and applicable deductible amounts **at the time of service** unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not pad our claim within 60 days, we may expect payment from you.
- If by mistake, hour health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons.

    1. This is a pre-existing illness hat is not covered by your plan.
    2. You have not met all of your full calendar year deductible.
    3. The type of medical services required is not covered by your plan.
    4. The health plan was not in effect at the time of service.
    5. you have other insurance which must be filed first.

Although benefits may be verified at the time of service, it is not a guarantee of payment on what was quoted. Please understand the financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any reason, you will be come responsible for this bill. **It is your responsibility as the patient to pay the denied amounts in full.**

Our primary mission is to provide you with quality, cost effective medical care. Together we are trying to adapt to the changing way that health care is financed and delivered

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Again, we value you as a patient and our priority is to provide you with the best possible care. We are pleased to welcome you to our practice.

Sincerely,

Lowery Family Chiropractic

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier.

_____	_____
Patient Signature	Date
_____	_____
Patient name- PRINTED	Account Number

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INFORMED CONSTENT

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes Chiropractic care. We want you to be informed about potential problems associated with Chiropractic Health Care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the Doctor's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, the Doctor will perform your consultation, examination, refer out for x-rays, MRI's, physical therapy application, traction, massage therapy, exercise instruction, ect.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustments that are related to the vertebral artery stroke is call Extension-Rotation-Thrust Atlas Adjustment. WE DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA. Vol. 37, No. 2 June 1993) estimate that the incidence of this type of stroke is 1 per 3,000,000 upper neck adjustments. This means that an average Chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniations: Disc herniations that created pressure on a spinal nerve or the spinal cord are frequently successfully treated by Chiropractors and Chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally Chiropractic treatment (adjustments, traction, ect.) will aggravate the problem and rarely, surgery may cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify there probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscle move bones and ligaments limit joint movement. Rarely, a Chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify there probability.

Rib Fracture: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a Chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patient very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify there probability.

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Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for Chiropractic adjustments, traction, massage therapy, exercise, ect., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform the Doctor.

Other Problems: There may be other problems or complications that might arise from Chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your Doctor. Once you have a full understanding please sign and date below.

Patient's Name (Printed)_____ Date _____

Patient's Signature _____

Guardian's Signature (If patient is a minor) _____

Witnessed by _____ Date _____

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Patient Health History Form

Patient Name: _____ Date _____

1. Reason for your visit? _____

2. When did your symptom(s) first appear? _____

3. Is this condition getting progressively worse Yes No Unknown

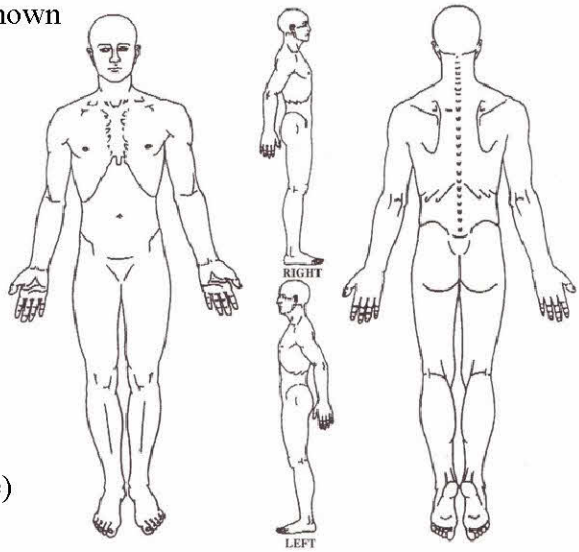
4. Mark the best one below which describes your type of pain?

Sharp	Dull	Throbbing	Numbness
Aching	Shooting	Burning	Tingling
Cramps	Stiffness	Swelling	Other_____

5. How often do you have this pain? _____

6. Is it constant or does it come and go? _____

7. How often do you experience your symptoms?
   Constantly (76-100% of time) Frequently (51-75% of time)
   Occasionally (25-50% of time) Intermittently (0-25% of time)



Pain Level 0-1-2-3-4-5-6-7-8-9-10

8. What treatment have you already received for your condition?
   Medications Surgery Physical Therapy Chiropractic Care
   None Other _____

9. Name and address of the doctor(s) who have treated your for this condition now or in the past._____
   _____

10. Dates of Last: Physical Exam: _____ Spinal X-ray: _____ Blood Test:_____
    Spinal Exam: _____ Chest X-ray: _____ Urine Test: _____
    Dental X-ray: _____ MRI,CT,Bone Scan: _____

11. Have you had any previous surgeries and what was the date and procedure?_____
    _____

12. What medications are your currently taking? _____
    _____

13. What Vitamins/Herbs/Minerals are your currently taking? _____
    _____

14. List any allergies you may have? _____
    _____

15. What is your occupation? _____
    _____

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