ACCT#_____ PATIENT INFORMATION

THE FOLLOWING INFORMATION IS NEEDED IN ORDER TO BETTER SERVE YOU. PLEASE ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY. PLEASE PRINT

Full Name _____ Sex: M F

Home Phone _____ Cell Phone _____ Work Phone_____

Address _____ City _____ State _____ Zip_____

Age _____ Birth Date _____ Marital Status: S M W D Number of Children_____

SSN# _____-____-_____ Driver's License # _____

Email Address _____

Employer _____ Occupation _____ # of Years _____

Name of Spouse / Subscriber _____ Spouse / Subscriber Date of Birth _____

Do you have Health Insurance? Yes No Are you the Subscriber? Yes ___ No ___

Insurance Company _____ Subscriber ID# _____ Plan / Group # _____

In Case of Emergency

Name of Spouse, Parent, or Guardian _____

Spouse's Employer _____ Spouse's Work Phone _____

Employer's Address _____ City _____ State _____ Zip_____

How did you find out about our office? _____

Is your condition today due to an accident? Yes ___ No ___ If so, Date of Accident _____

I (We) agree to pay for services rendered to the above-mentioned patient as the charge is occurred. I (We) understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I (We) also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I (We) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any Insurance Co., Attorney, or Adjustor in order to process any claim for reimbursement of charges incurred by me as a a result of professional services rendered and hereby release him / her of any consequence thereof. I agree that a Photostatic copy of this agreement shall service as the original.

I (We) hereby authorize and direct payment of any medical / chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a Photostatic copy of this agreement shall serve as the original.

Patient Signature _____ Date _____

Spouse or Guardian Signature _____ Date _____

1. Notice to our new patients: Full payment for services rendered is due at the end of each visit
2. Insurance cases: We gladly accept insurance assignment if your Insurance Co a) verified the deductible has been met, b) provides details of your coverage, and (c) agrees to make payment directly to our office
3. We file your primary Insurance at no charge to you. Filings for policies in addition to your primary coverage for a fee and as time permits

Thank You!

Name _____ Age _____ Sex: M F Date _____

What brings you into our office today? (Please Explain):

_____

_____

DETAILS OF THE CHIEF COMPLAINT:

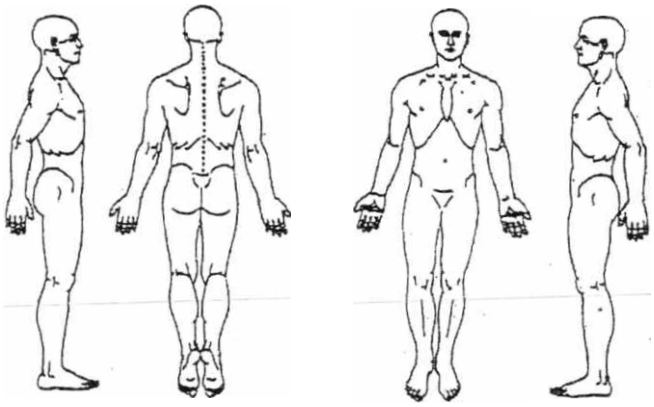
1. Location of Symptoms, Injury, or Pain:
   Using the adjacent body charts, please
   Circle all of the affected areas.
   Order of Appearance of Injury (Area)
   1. _____ 2. _____ 3. _____

   Intensity of Pain (0= no pain, 10=worst)

   1. _____2. _____ 3. _____

   (AMA Pain Scale: Minimal 1-3, Slight 4-6

   Moderate 7-9, Emergency 10)



2. Has your pain spread or radiated anywhere? Yes___ No___
   If so, where?_____
3. When and how did it start? _____
   _____
   Date of occurrence: _____ Date of First Visit _____
4. How would you describe your pain? (Sharp, Dull, Achy, etc.)
   _____
5. How often do you experience your problem? (% of day)
   ____ Intermittent 0-25% _____ Occasional 26-50% _____ Frequent 51-75% _____ Constant 76-100%
6. What aggravates your condition? (posture, activity, etc.) _____
   _____
7. Is this an aggravation of an old injury? Yes No
   Have you experienced anything similar to this in the past?_____
8. Have your symptoms changed since onset? Yes No
9. Have you noticed any change of bodily functions? Yes No (please check all that apply)

____ Balance	____ Bowel Habits	____ Breathing	____ Coordination
____ Coughing	____ Walking	____ Grip Strength	____ Hearing
____ Menstrual	____ Sexual	____ Sleep	____ Sneezing
____ Urination	____ Vision	____ Weakness	____ Weight

10. Handedness: Right _____ Left _____ Ambidextrous _____
11. Are there any activities that are harder to do or that you cannot do as a result of your condition?
    _____
12. Work Status: Full Time___ Part Time___ Student___ Retired___ Disabled___ Unemployed___

13. Work / Home Disability: Yes ____ No _____
    Complete: ____ Days off work
    ____ Days unable to perform Household tasks
    Partial: ____ Days of job modification
    ____ Days of decreased Household tasks
14. Have you used any store-bought or Home Remedies? Yes ____ No____
    If so, what? _____
    Did they help? _____ Have you tried Ice? _____ or Heat? _____
15. Are you able to find relief with certain activities, postures, time of the day, etc.? Yes ____ No ____
    If so, please explain _____
16. Have you been treated by anyone else for this problem? Yes ____ No ____
    If so, please identify who and what type of therapy? _=_____
17. Are you currently under a doctor's care for any other conditions? Yes ____ No ____ If so, please explain:
    _____
18. Have you suffered any physical injuries such as falls or blows, whiplash, concussion, or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? Yes ____ No ____
    If so, explain: _____
    _____
19. Please list any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
    _____ Date: _____
    _____ Date: _____
    _____ Date: _____
    _____ Date: _____
    _____ Date: _____
20. Have you ever been hospitalized for any reason other than surgery? Yes ____ No ____
21. Do you have a Pacemaker or any other Surgically Implanted Device? Yes ____ No ____
22. Are you now or could you be pregnant? Yes ____ No ____ Onset date of last Menstrual Cycle _____
23. Females, have you had menstrual problems? Yes ____ No ____ Explain _____
    Have you ever taken birth control pills? Yes ____ No ____ If so, for how long? _____
24. Do you have any nervous system diseases and / or mental health problems? Yes ____ No ____
    _____
25. Do you have any muscle, tendon, or ligament problems? Yes ____ No ____
26. Do you have any bone or joint diseases (ex. Bone= Osteoporosis, Joint=Arthritis)? Yes ____ No ____
27. Do you have any gland or hormone problems? Yes ____ No ____
28. Have you ever had cancer? Yes ____ No ____
29. Are you losing weight without trying? Yes ____ No ____
30. Does your pain wake you up at night? Yes ____ No ____
31. Have you had any change in bowel or bladder habits? Yes ____ No ____
32. Have you had a sore that does not heal? Yes ____ No ____
33. Have you recently had any unusual bleeding or discharge Yes ____ No ____

34. Medication: Please list all medications (prescriptions and non-prescriptions) you are currently taking or take on an occasional basis

Name of Medication	Dosage	Frequency

35. Do you have any allergies to medications? Yes ____ No ____ If so, what? _____
36. Do you consume alcohol? Yes ____ No ____ If so, how much? _____ How Often? _____
37. Do you use drugs? Yes ____ No ____ If so, what? _____
38. Do you currently smoke? Yes ____ No ____ If so,how much per day? _____ # of Years _____
39. Former smoker? Yes ____ No ____ How many years did you smoke? _____ How many years smoke free?____
40. Please describe postures and / or positions in which you work, as well as they type of work you do:

_____
_____
_____

41. In what position do you usually sleep, and how well? _____
42. Family History – Parents still living? Yes ____ No ____ Ages: _____

Parents deceased? Yes ____ No ____ Ages: _____

Any diseases or medical conditions for any family members? If yes, please explain relationship and condition:

_____
_____
_____ _____

Miscellaneous Notes:

_____
_____
_____
_____

Doctor Notes: _____
_____
_____
_ _____
_____
_____
_____

Name _____ Age _____ Sex: M___ F___ Date _____

Have you ever (at any time) experience any of the following?

Difficulty Urinating	Y	N	Claustrophobia	Y	N
Loss of bladder control	Y	N	Spinal Surgery	Y	N
Loss of bowel control	Y	N	Common Cold / Flu	Y	N
Temporary loss of vision, one eye	Y	N	Carotid Artery Surgery	Y	N
Blood in Urine	Y	N	Breast Reduction	Y	N

Have you ever been diagnosed with or told you have one of the following?

Detached Retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured / Broken Vertebra	Y	N
Slipped Disc	Y	N	Bleeding Disorder	Y	N
Herniated Disc	Y	N	High Blood Pressure	Y	N
Osteoporosis	Y	N	Blood in Stool	Y	N
TIA's (pin or mini strokes)	Y	N	Cancer	Y	N
Drop Attacks (collapsing)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney Disease	Y	N
Partial or complete paralysis	Y	N	Prostate Disease	Y	N
Diabetes	Y	N			

In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Y	N	Vomiting	Y	N
Vertigo (spinning)	Y	N	Difficulty Walking	Y	N
Incoordination	Y	N	Numbness or other sensory change	Y	N
Loss of consciousness	Y	N	Double Vision	Y	N
Tinnitus (ringing in ears)	Y	N	Blurred Vision	Y	N
Speech problems	Y	N	Clumsiness	Y	N
Memory Loss	Y	N	Personality changes	Y	N
Fever	Y	N	Recurrent headaches	Y	N
Diarrhea	Y	N	A Major Fall	Y	N
Skin rash / infection	Y	N	A Minor Fall	Y	N
Loss of strength	Y	N	An Auto Accident	Y	N
Pain moving bowels	Y	N	A Work Injury	Y	N
Abnormal periods	Y	N	Head Trauma	Y	N

Do you *currently* have any of the following?

Integument System / Endocrine System

Skin Rash	Y	N	Hormone problems	Y	N
Skin Lesions	Y	N	Hot Flashes	Y	N
Changes in skin color	Y	N	Thyroid problems	Y	N
Itching (pruitus)	Y	N	Hormone therapy	Y	N
Hair changes	Y	N	Growth abnormalities	Y	N
Nail changes	Y	N	Metabolism changes	Y	N

Digestive System

Abdominal pain	Y	N	Rectal bleeding	Y	N
Nausea	Y	N	Jaundice	Y	N
Vomiting	Y	N	Abdominal distention	Y	N
Constipation	Y	N	Cramping	Y	N
Diarrhea	Y	N	Lumps / mass	Y	N

(Please continue on the next page)

Cardiovascular System

Chest pain	Y	N	Changes in skin color	Y	N
Irregular Heartbeat	Y	N	Stroke	Y	N
Shortness of breath	Y	N	Dizziness	Y	N
Fainting	Y	N	Cool hands or feet	Y	N
Fatigue	Y	N	Varicose veins	Y	N
Swelling in the legs	Y	N	Pin Stroke	Y	N

Pulmonary System

Musculoskeletal System

Coughing	Y	N	Stiffness	Y	N
Sputum production	Y	N	Popping noises	Y	N
Coughing up blood	Y	N	Joint Pain	Y	N
Shortness of breath	Y	N	Weakness	Y	N
Wheezing	Y	N	Limitation of movement	Y	N
Blue skin (cyanosis)	Y	N	Extremity deformities	Y	N
Chest pain	Y	N	Difficulty walking	Y	N

Nervous System

Partial Paralysis	Y	N	Lack of Coordination	Y	N
Complete Paralysis	Y	N	Stroke	Y	N
Headache	Y	N	Speech Abnormalities	Y	N
Loss of Consciousness	Y	N	Visual disturbances	Y	N
Dizziness	Y	N	Walking disorders	Y	N
Memory loss	Y	N	Tremors	Y	N
Numbness	Y	N	Tics	Y	N
Weakness	Y	N	Sensory changes	Y	N
Mood changes	Y	N			

Genital / Urinary System

Special Senses

Pain on urination	Y	N	Visual Problems	Y	N
Changes in urine flow	Y	N	Hearing Loss	Y	N
Lump or mass in groin	Y	N	Loss of balance	Y	N
Kidney stones	Y	N	Loss of taste	Y	N
Chronic bladder Infections	Y	N	Loss of smell	Y	N
Genital Itching	Y	N	Loss of touch sensation	Y	N
Changes in urination	Y	N	Temporary vision loss in one eye	Y	N

Reproductive System

Male Only

Female Only

Testicular pain	Y	N	Abnormal Vaginal bleeding	Y	N
Prostate problems	Y	N	Painful menstruation	Y	N
Infertility	Y	N	Breast lump / mass	Y	N
Impotence	Y	N	Vaginal discharge / itching	Y	N
Discharge	Y	N	Nipple discharge	Y	N
Lump or mass	Y	N	Infertility	Y	N
Male pattern baldness	Y	N	Abnormal periods	Y	N

Head and Neck Region

Headaches	Y	N	Ringing in ears	Y	N
Neck stiffness	Y	N	Ear pain	Y	N
Neck lump / mass	Y	N	Ear discharge	Y	N
Eye pain	Y	N	Ear itching	Y	N
Eye discharge	Y	N	Nasal discharge	Y	N
Double vision	Y	N	Sinus trouble	Y	N
Dry Eyes	Y	N	Bad breath	Y	N
Excessive tearing	Y	N	Nasal Obstruction	Y	N
Spinning sensation	Y	N	Snoring	Y	N

Loveland Chiropractic
215 Loveland – Madeira Road, Loveland, OH 45140
513-683-1052

CONSENT TO TREAT

Informed Consent

To the patient: Please read the entire document prior to signing it. It is important that you understand the information contained in this document, so please ask us if you have any questions.

The nature of chiropractic adjustment: The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may utilize hands-on or mechanical instrument manipulations to move your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement. Common benefits of the above treatment include improved mobility and reduced pain.

Analysis / Examination / Treatment:
As apart of the analysis, examination, and treatment, you are consenting to thee following procedures as they are recommended for you: spinal manipulative therapy, palpation, vital signs, orthopedic and basic neurological testing, range of motion, muscle strength testing, postural analysis, ultrasound, hot / cold therapy, radiographic studies, electrical muscle stimulation, dry needling (piercing the skin with fine-gauge needles), spinal decompression therapy (traction), rehabilitation stretching and strengthening, nutritional analysis / therapy, massage therapy, muscle therapy, and other treatments and tests as deemed necessary.

The material risks inherent in chiropractic treatment:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation (CMT) and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strains, cervical myelopathy, pneumothorax, bruising, burns, and infection or blood-borne illness. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care. If you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

The probability of those risks occurring:
Fractures caused from spinal manipulation are extremely rare. Patients suffering from bone weakening conditions like osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for these patients. Please inform the doctor if you have a bone weakening disease. Researchers have found no evidence of excess risk of VBA stroke associated with chiropractic care compared to primary care. However, if there is a causal relationship between manipulation and stroke, it is rare and remote. Please inform us of any personal or family history of stroke. There have been some reports of herniated or ruptured discs caused by spinal manipulation or mechanical traction. In rare circumstances dry needling has been reported to cause pneumothorax and infection. We practice evidence-based manipulation procedures and follow guidelines for all therapies to minimize risk. The risk of all other complications (material risks) mentioned above are rare, but it is not uncommon to experience minor soreness following the initial treatments.

The availability and nature of other treatment options:

One of the most common treatment options for the conditions we treat is self-administered, over- the-counter medications such as NSAIDs. Spinal manipulation is significantly safer than NSAIDS when comparing risk of adverse events. Prescription oral medications, injections, and surgical interventions are other treatment options that commonly carry significant risk.

The risks and dangers of conditions remaining untreated or undertreated:

Early intervention to restore normal function and compliance with the treatment plan are both essential in an effort to prevent conditions from progressing to a further chronic pain/symptom state.

Consent to Treat a Minor (Required for all patients under 18 years old)

I hereby request and authorize this clinic to perform diagnostic tests and render treatment to my minor (son/daughter/other) _____. This authorization extends to all doctors and staff members and includes radiographic examination at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor named above. Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office. I also consent to the minor listed above to be treated without me present in the office.

ALL PATIENTS:

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read [ ] or have had read to me [ ] the above explanation of the examination and treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the benefits, risks, and alternatives, I hereby give my consent to all examination, testing, and treatment described above.

Patients Name: _____ Doctors Name: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Signature of Parent or Guardian (if patient is a minor) _____

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OFFICE POLICY LETTER

IN ORDER TO CONTROL OUR COST OF BILLING, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, Medicaid and other health plans to: Loveland Chiropractic Offices, Inc., 215 Loveland Madeira Rd, Loveland, OH 45140.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of any medical records.

In the event that full payment for charges incurred in connection with my medical care is not made, I agree to pay all costs of collection, including reasonable attorney's fees. I also agree to submit myself to the jurisdiction of the courts of Hamilton, Ohio.

This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

Signed _____ Date _____
(Responsible Party)

DESIGNATION OF AUTHORIZATION REPRESENTATIVE

I, _____ , do hereby designate Jeffrey T. Kemmet, D.C. and Loveland Chiropractic Offices, Inc. (hereafter referred to "my doctor"), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-l(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of services I receive from the above-named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the services I receive from my doctor.

Signed _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

This form will be trained in your medical record.

Notice to Patient

We are required to provide a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice.

I acknowledge that I received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Loveland Chiropractic Offices.

I understand that the Notices describes the uses and disclosures of my protected health information by Loveland Chiropractic Offices and informs me of my rights with respect to my protected health information. Please indicate other people (a spouse, significant other, or relative) you will allow this clinic to share aspects of your treatment and protected health information (including your medical information, billing information and/or scheduled appointments). You may choose to allow none.

Authorization to Release Information

1. _____ _____ _____
   Name Relationship Phone

2. _____ _____ _____
   Name Relationship Phone

3. _____ _____ _____
   Name Relationship Phone

Please indicate if you allow this clinic to leave information about your medical information, billing, and scheduled appointments (protected health information) in a voicemail or email as needed. Please initial each that you allow. You may choose to allow none.

Text: Yes ____ No____ (appointment reminder) Voicemail Yes ____ No ____ Email Yes ____ No ____

Phone Number: _____ Email Address:_____

_____ _____
Patient's Signature or that of Legal Representative Printed Name of Patient or that of Legal Representative

_____ _____
Today's Date If Legal Representative, Indicate Relationship

Primary Care Physician (PCP)

Name and Address Form

Patient Name: _____

PCP Name: _____

PCP Address:_____

_____

_ _____

PCP Phone: _____

PCP Fax: _____

----------Office Use Only----------

Entered in computer on: _____
Date

Initial: _____