LOVE CHIROPRACTIC, Inc.

Dr. David B. Love, D.C. 1220 41st Avenue, Suite I • Capitola CA 95010

Name _____ Today's Date _____

Address _____ City _____

State _____ Zip _____ Age _____ Height _____ Weight _____

Date of Birth _____ ❑ Male ❑ Female

❑ Single ❑ Married ❑ Divorced # of Children _____ Name of spouse (or parent) _____

Your **Email address** _____ Cell Phone _____

Who referred you to our office? _____ Home Phone _____

Your **Employer** _____ Work Phone _____

Emergency contact info: Name _____ Phone _____

Had Chiropractic Care previously? _____ If yes, when? _____

List your **Chief Complaints** in order of severity (highest 1st)

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____

Has this problem been **staying the same**, getting **better**, **worse**,? _____

List **other doctors** consulted for this condition:

1. _____ 2. _____

Are you covered under **Heatlh Insurance**? ❑Yes ❑No Insured's name _____

Relation to patient _____

Do you have **secondary insurance** coverage? ❑ Yes ❑ No Insured's name _____

Relation to patient _____

Is this injury/illness **related to an auto accident**? ❑ Yes ❑ No Name of your auto insurance _____

Auto policy number _____ Claim number _____

Agent's name / phone number _____

Is this injury/illness **work related**? ❑ Yes ❑ No Have you reported it to your employer? ❑ Yes ❑ No

Currently or in the past **have you ever experienced any of these complaints while working**? _____ If yes, please describe what activities at work may be causing you to experience these complaints:

_____

Are there any **activities or incidents outside of work** that may have caused these complaints? ❑Yes ❑ No

If yes, please explain: _____

Have you ever had any **surgeries/hospitalizations?** (if yes, please list) _____

Please list injuries or illness that you have had in the past that are not listed above _____

Drugs you now take: ❑ Aspirin/Tylenol ❑ Pain killers ❑ Muscle relaxers ❑ Tranquilizers ❑

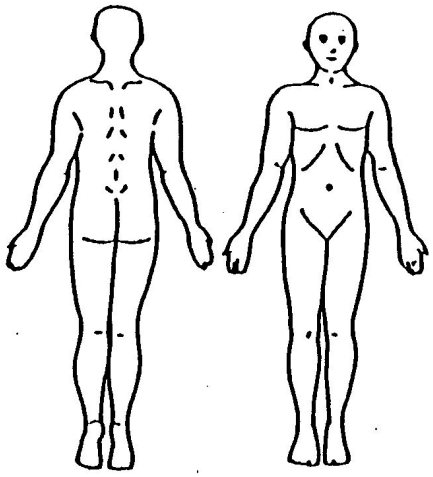
❑ Birth control pills ❑ Other (please list): _____

PAIN DIAGRAM

Use the letters below to mark on the diagram the *type* and *location* of pain and sensations…

KEY

A = ache
B = burning
S = stabbing
N = numbness
P = pins & needles
O = other



Who is your **primary medical doctor ?** _____

Is it OK for us to communicate with him/her? This way we can make sure that you are getting the best care from both your chiropractor and your medical doctor. ❑ Yes ❑ No

** Please allow us to make a copy of your insurance card(s)

Method of payment you plan to use for today's charges: ❑ Check ❑ Cash ❑ Credit Card

NOTICE: Not all patients require x-rays to determine or verify diagnosis, type of treatment, and treatment length. If your examination warrants x-ray analysis, the following office policy will be utilized:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires that we maintain your x-ray film(s) as part of your records in our office. After the films are used for the purpose of analysis, they can be released for evaluation to another facility only after written patient authorization.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally

responsible for payment. I agree to immediately surrender to this office any payments and paperwork that are sent to me directly by an insurance company as payment for services rendered by Dr. Love. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor and/or his office staff to leave, if necessary, a voicemail message(s) on my home and/or cell phone. (Initial ____)

I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine and/or extremity. I also agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition, nor for any medical diagnosis.

Patient signature _____ Date _____

Guardian or Spouse's
signature authorizing care _____ Date _____