

Welcome

Lott Chiropractic Clinic, P.C.
Dr. Gregory Lott
(402) 489-0777

PATIENT INFORMATION

Date: _____

Patient Name: _____ Social Security #: _____

Address: _____ City, State: _____ Zip: _____

Primary Phone: _____ H / C / W Secondary Phone: _____ H / C / W

Email: _____ Gender: Male Female Birth Date: _____

Relationship Status: Married Widowed Single Minor Separated Divorced Partnered

Spouse/Partner: _____ # of Children: _____ Ages: _____

Occupation: _____ Employer: _____

Job Activities: _____

How did you hear about us? Phone Book Website Ad Existing Patient: _____

WOMEN ONLY: To the best of your knowledge, are you currently pregnant? No Yes, Due Date: _____

INSURANCE PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK STAFF, SO THAT HE/SHE MAY MAKE A COPY

Insurance Company: _____ ID: _____

If the primary insured is someone other than the patient: Name of Insured: _____

Relationship to Insured: Spouse Child Insured's Birth Date: _____

Insured's Address: _____

Are you seeking treatment for an injury sustained in a Motor Vehicle or Work-Related Accident? No Yes

If YES, please speak to the front desk staff so that he/she can collect the appropriate additional information from you.

CURRENT CONDITION

MARK YOUR AREA(S) OF DISCOMFORT

1. Describe your current condition: _____

Secondary Condition: _____

2. When did your symptoms appear? _____

3. My condition is: Getting Worse Spreading Improving Unchanged

4. Mark the severity of your pain on the scale:
← No Pain Mild Moderate Severe Intolerable →

5. Type of Pain: Sharp Dull Throbbing Numbness Aching
 Shooting Burning Cramps Tingling Stiffness Swelling

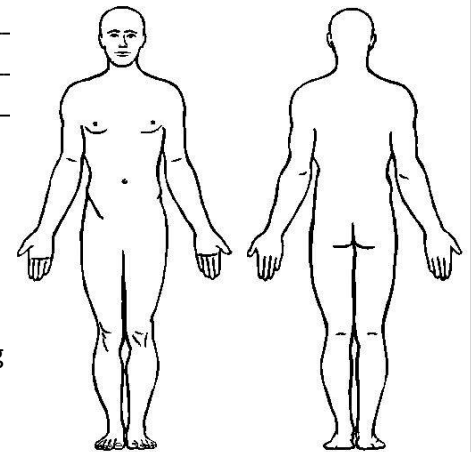
6. How often do you have this pain? Constant Frequent (~75% of the time)
 Intermittent (~50% of the time) Occasional (~25% of the time)

7. Which activities provoke or aggravate your condition? Sitting Standing Walking Lying Down Hot/Cold
 Pushing Pulling Lifting Gripping Coughing/Sneezing Bending Bright Lights _____

8. Which activities help to alleviate your pain? Lying Down Sitting Walking Standing Resting Massage
 Hot/Cold Stretching Massage Darkness/Quiet Medications Other: _____

9. Which treatment(s) have you already received for your current condition? Medications Surgery
 Physical Therapy Chiropractic None Other: _____

10. Name and address of other doctor(s) who have treated you for this condition (if applicable): _____



PHYSICIANS & MEDICAL HISTORY

Family Physician: _____ Medical Specialist(s): _____

Have you previously received Chiropractic Care? No Yes, with Dr. _____, For: _____

Injuries, Accidents, Falls/Traumas: No Yes, _____

Illnesses/Hospitalizations: No Yes, _____

Surgeries: No Yes, _____

X-rays, MRI, CT or Other Imaging: No Yes, _____

Other Conditions the Doctor should know about: _____

PERSONAL HABITS

Tobacco: None Yes, _____ Packs/Cans per Week

Sleep: None Yes, _____ Hours/Night

Alcohol: None Yes, _____ Drinks/Week

Coffee: None Yes, _____ Cups/Week

Water: None Yes, _____ Ounces/Day

Soft Drinks: None Yes, _____ Bottles/Cans per Week

Recreational Drugs: None Yes, Type: _____, Frequency: _____, Years of Use: _____

Exercise: None Yes, _____ Hours/Week; What type of exercise? _____

Eating: _____ Meals/Day; What types of food do you eat primarily? _____

Do you consider your diet healthy? No Yes Explain: _____

HOW WOULD YOU DESCRIBE YOUR CURRENT...

Emotional State: Excellent Good Average Below Average Poor

Concentration: Excellent Good Average Below Average Poor

Exercise Level: Excellent Good Average Below Average Poor

Dietary Habits: Excellent Good Average Below Average Poor

Overall Health: Excellent Good Average Below Average Poor

VITAMINS, MINERALS & SUPPLEMENTS

Amount & Frequency

VITAMINS, MINERALS & SUPPLEMENTS	Amount & Frequency

I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Lott may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Further, I understand that it is my responsibility to keep Dr. Lott and his staff apprised of any changes in insurance coverage. If there is a lapse in my insurance coverage, I understand that I am responsible for any fees incurred. If ever I elect not to furnish insurance information for the submission of claims relating to my treatments, I realize that I am financially responsible for any and all treatments that I receive while under the care of Dr. Lott. I realize that, in this case, I have the option of receiving a Time-of-Service Discount. If I choose one of this option, the discounted services and treatments I receive from Dr. Lott are not allowed to be submitted to any insurance company for reimbursement, either by myself or any agent acting on my behalf.

Signature: _____

Date: _____