Welcome

2855 S. 70th Street, Suite 101 Lincoln, NE 68506

Dr. Gregory Lott (402) 489-0777
Dr. Austin Weaver (402) 483-4409

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

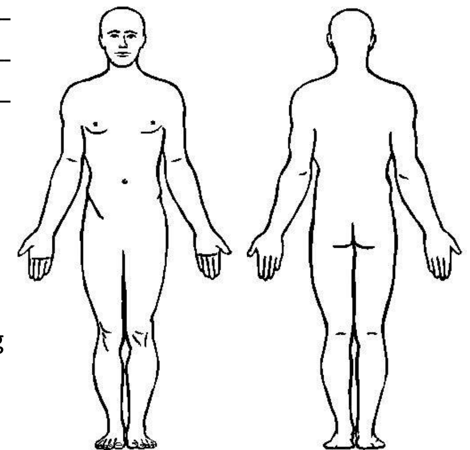
PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK STAFF, SO THAT HE/SHE MAY MAKE A COPY

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**: __________________
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 AREAS 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): ________________

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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: ____

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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

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 and/or Dr. Weaver 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/or Dr. Weaver and his/their 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 treatment that I receive while treating with Dr. Lott and/or Dr. Weaver. I realize that, in this case, I have the option of receiving a Time-of-Service Discount or joining the Preferred Chiropractic Doctor program. If I choose one of these options, the discounted services and treatments I receive from Dr. Lott and/or Dr. Weaver are not allowed to be submitted to any insurance company for reimbursement, either by myself or any agent acting on my behalf.

Signature: ____ **Date**: _______________________