Welcome to Chiropractic

Please Print Clearly and fill In completely.

Name_____**Email**_____**DOB**_____

Address_____**Phone**_____

City_____**State**_____**Zip**_____**SS#**_____

Please Check ✓ Sex: Male❑ Female❑ Right handed❑ Left handed❑ Married❑ Single❑

Health History:

Give reason for seeking chiropractic care:_____

_____

Describe any health problems, including how long you've had them:_____

_____

Are you under the care of any other doctor? Yes❑ No❑
If Yes, the conditions being treated for:

_____

List any current Medications:_____

List any past surgeries & dates:_____

List any past accidents & dates:_____

List any x-rays you've had in the past 2 years:_____

Personal & Family History:

Your Occupation:_____ Work Duties_____

Spouse's health status_____

Children's ages and health status:_____

Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name_____

Date of last chiropractic visit_____Reason for care_____

Date of last chiropractic x-rays_____How long were you under care?_____

Are other family members under chiropractic care? - Yes❑ No❑ Who?_____

Wellness Commitment

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%--------20%--------30%--------40%--------50%--------60%--------70%--------80%--------90%--------100%

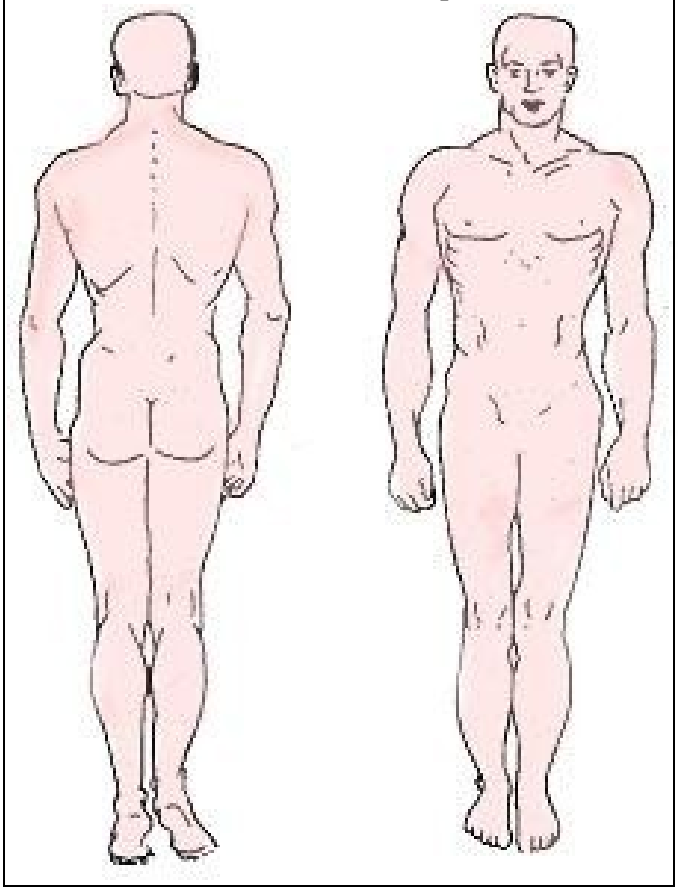
Where did you hear about our clinic,
or who referred you?_____

FEMALES: ***Please Check One*** ✓ Is there a possibility of you being pregnant? **Yes❑** **No❑**

Please Fill in Below If you have had the following, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other joint pain	❑	❑
Numbness	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Nausea	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Heart Problems	❑	❑
Frequent colds	❑	❑
Nose Bleeds	❑	❑
Ringing in Ears	❑	❑
Earaches	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest pains	❑	❑
Female problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Digestive problem	❑	❑
Urinary Problems	❑	❑
Skin conditions	❑	❑
Other _____	❑	❑

Circle the areas where you have any problems.
Please also describe these problems.



Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please

_____

Date: _____

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Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
1	Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
2	Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
3	Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
4	Are you able to run errands and shop?	☐	☐	☐	☐	☐
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
5	I felt fearful	☐	☐	☐	☐	☐
6	I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
7	My worries overwhelmed me	☐	☐	☐	☐	☐
8	I felt uneasy	☐	☐	☐	☐	☐
	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
9	I felt worthless	☐	☐	☐	☐	☐
10	I felt helpless	☐	☐	☐	☐	☐
11	I felt depressed	☐	☐	☐	☐	☐
12	I felt hopeless	☐	☐	☐	☐	☐
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
13	I feel fatigued	☐	☐	☐	☐	☐
14	I have trouble starting things because I am tired	☐	☐	☐	☐	☐
	In the past 7 days…					
15	How run-down did you feel on average?	☐	☐	☐	☐	☐
	In the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
16	How fatigued were you on average?	☐	☐	☐	☐	☐

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Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
17	My sleep quality was.....	☐	☐	☐	☐	☐

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
18	My sleep was refreshing.....	☐	☐	☐	☐	☐
19	I had a problem with my sleep	☐	☐	☐	☐	☐
20	I had difficulty falling asleep	☐	☐	☐	☐	☐

Satisfaction with Social Role

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
21	I am satisfied with how much work I can do (include work at home)	☐	☐	☐	☐	☐
22	I am satisfied with my ability to work (include work at home)……	☐	☐	☐	☐	☐
23	I am satisfied with my ability to do regular personal and household responsibilities	☐	☐	☐	☐	☐
24	I am satisfied with my ability to perform my daily routines.....	☐	☐	☐	☐	☐

Pain Interference

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
25	How much did pain interfere with your day to day activities?.....	☐	☐	☐	☐	☐
26	How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
27	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
28	How much did pain interfere with your household chores?	☐	☐	☐	☐	☐

Pain Intensity

In the past 7 days…

29	How would you rate your pain on average?.....	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst imaginable pain**

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Notice of Privacy Practices
April 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

Mark J. Levitan, DC, PC (DC, PC) may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. DC, PC has established a policy and procedures regarding disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED by DC, PC:

To Make or Obtain Payment. DC, PC may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, DC, PC may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. DC, PC may use or disclose health information for its own operations to facilitate the administration of the DC, PC health plan and, as necessary, to provide coverage and services to all of DC, PC's participants. Health care operations includes such activities as:

-- Quality assessment and improvement activities.
-- Activities designed to improve health care or reduce health care costs.
-- Clinical guideline and protocol development, case management and care coordination.
-- Contacting health care providers and participants with information about treatment alternatives and other related functions.
-- Health care professional competence or qualifications review and performance evaluation.
-- Accreditation, certification, licensing, or credentialing activities.
-- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
-- Review and auditing, including compliance reviews, medical reviews, legal services, and compliance programs.
-- Business planning and development including cost management and planning related analyses and formulary development.
-- Business management and general administrative activities of the DC, PC health plan, including customer service and resolution of internal grievances.
-- For example, DC, PC may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Distribution of Health-Related Benefits and Services. DC, PC may use or disclose your health information to provide you with information on health-related benefits and services.

When Legally Required. DC, PC will disclose your health information when it is required to do so by any federal, state, or local law.

To Conduct Health Oversight Activities. DC, PC may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure, or disciplinary action. DC, PC, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, DC, PC may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when DC, PC makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, DC, PC may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if DC, PC has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety. DC, PC may, consistent with applicable law and ethical standards of conduct, disclose your health information if DC, PC, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require DC, PC to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Worker's Compensation. DC, PC may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, DC, PC will not disclose your health information other than with your written authorization. If you authorize DC, PC to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that DC, PC maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on DC, PC's disclosure of your health information to someone involved in the payment of your care. However, DC, PC is not required to agree to your request. If you wish to make a request for restrictions, please contact the DC, PC Contact Person at 631-722-1722.

Right to Receive Confidential Communications. You have the right to request that DC, PC communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that DC, PC only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the DC, PC Contact Person at Mark J. Levitan, D.C., P.C., 406 Larkfield Road, East Northport, New York 11731, or email to info@levitanchiropractic.com. DC, PC will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the DC, PC Contact Person at Mark J. Levitan, D.C., P.C., 406 Larkfield Road, East Northport, New York 11731, or email to info@levitanchiropractic.com.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that DC, PC amend the records. That request may be made as long as the information is maintained by DC, PC. A request for an amendment of records must be made in writing to the DC, PC Contact Person at Mark J. Levitan, D.C., P.C., 406 Larkfield Road, East Northport, New York 11731, or email to info@levitanchiropractic.com. DC, PC may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by DC, PC, if the health information you are requesting to amend is not part of DC, PC 's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if DC, PC determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by DC, PC for any reason other than for treatment, payment, or health operations. The request must be made in writing to the DC, PC Contact Person at Mark J. Levitan, D.C., P.C., 406 Larkfield Road, East Northport, New York 11731, or email to info@levitanchiropractic.com. The request should specify the time period for which you are requesting the information but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the DC, PC Contact Person at 631-722-1722.

DUTIES OF MARK J. LEVITAN, D.C., P.C.

DC, PC is required by law to maintain the privacy of your health information as set forth in this Notice and to provide you this Notice of its duties and privacy practices. DC, PC is required to abide by the terms of this Notice, which may be amended from time to time. DC, PC reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If DC, PC changes its policies and procedures, DC, PC will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to DC, PC and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to DC, PC should be made in writing to the DC, PC Privacy Officer or the DC, PC Contact Person at Mark J. Levitan, D.C., P.C., 406 Larkfield Road, East Northport, New York 11731, or email to info@levitanchiropractic.com. DC, PC encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

DC, PC has designated Mark J. Levitan, D.C. as its Contact Person for all issues regarding patient privacy and your privacy rights. You may contact him at Mark J. Levitan, D.C., P.C., 406 Larkfield Road, East Northport, New York 11731, or email to info@levitanchiropractic.com.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT *the DC, PC Contact Person at Mark J. Levitan, D.C., P.C., 406 Larkfield Road, East Northport, New York 11731, or email to info@levitanchiropractic.com.*

MARK J. LEVITAN, D.C., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____, acknowledge and agree that I have received a copy of Mark J. Levitan, D.C., P.C.'s Notice of Privacy Practices.

Patient's Date of Birth _____

_____	_____
Patient Signature	Date
_____	_____
Patient Legal Representative (if applicable)	Date
_____	_____
Print Name of Legal Representative	Relationship to Patient

Please indicate if you wish for there to be any restrictions on the manner in which our office communicates with you regarding your health condition, health care, treatment, services, and/or payment.

☐ _____

☐ No Restrictions