

Adult Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name: Last Name: Date:

SS#: DOB: Sex: ☐ M ☐ F

Marital Status: # of Children: Occupation:

Street Address: Height: ft. in.

City: State: Zip: Weight: lbs.

Email: Cell Phone: Other Phone:

Emergency Contact: Emergency Relation: Emergency Phone:

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit:

Are you also receiving care from any other health professionals? ☐ Yes ☐ No

- If yes, please name them and their specialty:

Please note any significant family medical history:

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

Have you received care for this problem before? ☐ Yes ☐ No

- If yes, please explain:

When did the condition(s) first begin?

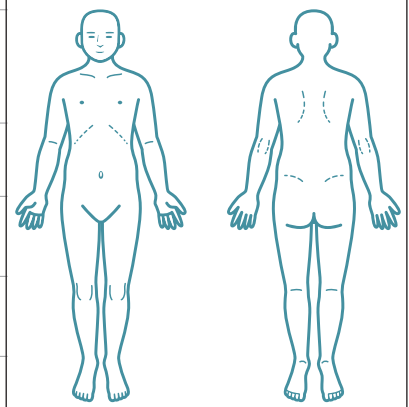
How did the problem start? ☐ Suddenly ☐ Gradually ☐ Post-Injury

Is this condition: ☐ Getting worse ☐ Improving ☐ Intermittent ☐ Constant ☐ Unsure

What makes the problem better?

What makes the problem worse?

Please indicate where you are experiencing pain or discomfort.



YOUR HEALTH GOALS

Your top three health goals:

1. _____
2. _____
3. _____

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ☐ Resolve existing condition(s) ☐ Overall wellness ☐ Both

Have you ever visited a chiropractor? ☐ Yes ☐ No If yes, what is their name?

What is their specialty? ☐ Pain Relief ☐ Physical Therapy & Rehab ☐ Nutritional ☐ Subluxation-based ☐ Other:

Do you have any health concerns for other family members today?

TRAUMAS: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ☐ Yes ☐ No

- If yes, please explain:

Notable childhood injuries? ☐ Yes ☐ No If yes, please explain:

Youth or college sports? ☐ Yes ☐ No If yes, list major injuries:

Any auto accidents? ☐ Yes ☐ No If yes, please explain:

Exercise Frequency? ☐ None ☐ 1-2x per week ☐ 3-5x per week ☐ Daily

What types of exercise?

How do you normally sleep? ☐ Back ☐ Side ☐ Stomach Do you wake up: ☐ Refreshed and ready ☐ Stiff and tired

Do you commute to work? ☐ Yes ☐ No If yes, how many minutes per day?

List any problems with flexibility. (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None						None				
	1	2	3	4	5		1	2	3	4	5
Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

Please list any drugs/medications/vitamins/herbs/other that you are taking, and why.

THOUGHTS: Emotional Stresses & Challenges

Please rate your STRESS for each:

	None						None				
	1	2	3	4	5		1	2	3	4	5
Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

ACKNOWLEDGEMENT & CONSENT

Patient Name: _____ Date: _____

Dr. Mark J. Levitan | Levitan Chiropractic

406 Larkfield Road, East Northport, NY | 631-722-1722

mlevitandc@gmail.com | www.LevitanChiropractic.com

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS			
		PAST PRESENT	PAST PRESENT		
Cervical	• Autonomic Nervous System	<input type="checkbox"/> <input type="checkbox"/>	Colic & Excessive Crying	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy & Seizures
	• ENT System	<input type="checkbox"/> <input type="checkbox"/>	Ear & Sinus Infections	<input type="checkbox"/> <input type="checkbox"/>	Sensory & Spectrum
	• Vision, Balance & Coordination	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Congestion	<input type="checkbox"/> <input type="checkbox"/>	ADD / ADHD
	• Speech	<input type="checkbox"/> <input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/> <input type="checkbox"/>	Focus & Memory Issues
	• Immune System	<input type="checkbox"/> <input type="checkbox"/>	Headaches & Migraines	<input type="checkbox"/> <input type="checkbox"/>	Anxiety & Stress
	• Digestive System	<input type="checkbox"/> <input type="checkbox"/>	Vertigo & Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Balance & Coordination
	• Nerve Supply to Shoulders, Arms & Hands	<input type="checkbox"/> <input type="checkbox"/>	Sore Throat & Strep	<input type="checkbox"/> <input type="checkbox"/>	Speech Issues
	• Sympathetic Nucleus	<input type="checkbox"/> <input type="checkbox"/>	Swollen Tonsils & Adenoids	<input type="checkbox"/> <input type="checkbox"/>	TMJ / Jaw Pain
	• Metabolism	<input type="checkbox"/> <input type="checkbox"/>	Vision & Hearing Issues	<input type="checkbox"/> <input type="checkbox"/>	Stiff Neck & Shoulders
			<input type="checkbox"/> <input type="checkbox"/>	Low Energy & Fatigue	<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure
		<input type="checkbox"/> <input type="checkbox"/>	Pain, Numbness & Tingling in Arms to Hands	<input type="checkbox"/> <input type="checkbox"/>	Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I.	<input type="checkbox"/> <input type="checkbox"/>	Reflux / GERD	<input type="checkbox"/> <input type="checkbox"/>	Bronchitis & Pneumonia
	• Respiratory System	<input type="checkbox"/> <input type="checkbox"/>	Chronic Colds & Cough	<input type="checkbox"/> <input type="checkbox"/>	Functional Heart Conditions
	• Cardiac Function	<input type="checkbox"/> <input type="checkbox"/>	Asthma		
Mid Thoracic	• Major Digestive Center	<input type="checkbox"/> <input type="checkbox"/>	Gallbladder Pain / Issues	<input type="checkbox"/> <input type="checkbox"/>	Indigestion & Heartburn
	• Detox & Immunity	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Stomach Pains & Ulcers
		<input type="checkbox"/> <input type="checkbox"/>	Fever	<input type="checkbox"/> <input type="checkbox"/>	Blood Sugar Problems
Lower Thoracic	• Stress Response	<input type="checkbox"/> <input type="checkbox"/>	Behavior Issues	<input type="checkbox"/> <input type="checkbox"/>	Allergies & Eczema
	• Filtration & Elimination	<input type="checkbox"/> <input type="checkbox"/>	Hyperactivity	<input type="checkbox"/> <input type="checkbox"/>	Skin Conditions / Rash
	• Gut & Digestion	<input type="checkbox"/> <input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/> <input type="checkbox"/>	Kidney Problems
	• Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Chronic Stress	<input type="checkbox"/> <input type="checkbox"/>	Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility)	<input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/>	Sciatica & Radiating Pain
		<input type="checkbox"/> <input type="checkbox"/>	Chrohn's, Colitis & IBS	<input type="checkbox"/> <input type="checkbox"/>	Lumbopelvic / SI Joint Pain
	• Gut-Immune System	<input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Hamstring Tightness
	• Major Hormonal Control	<input type="checkbox"/> <input type="checkbox"/>	Bed-wetting	<input type="checkbox"/> <input type="checkbox"/>	Disc Degeneration
		<input type="checkbox"/> <input type="checkbox"/>	Bladder & Urination Issues	<input type="checkbox"/> <input type="checkbox"/>	Leg Weakness & Cramps
		<input type="checkbox"/> <input type="checkbox"/>	Cramps & Menstrual Issues	<input type="checkbox"/> <input type="checkbox"/>	Poor Circulation & Cold Feet
		<input type="checkbox"/> <input type="checkbox"/>	Cysts & Endometriosis	<input type="checkbox"/> <input type="checkbox"/>	Knee, Ankle & Foot Pain
		<input type="checkbox"/> <input type="checkbox"/>	Infertility	<input type="checkbox"/> <input type="checkbox"/>	Weak Ankles & Arches
		<input type="checkbox"/> <input type="checkbox"/>	Impotency	<input type="checkbox"/> <input type="checkbox"/>	Lower Back Pain
		<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Gluten & Casein Intolerance

Patient Name: _____

Date: _____

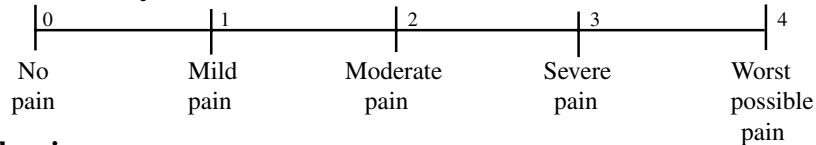
Functional Rating Index

For use with Neck and/or Back Problems only.

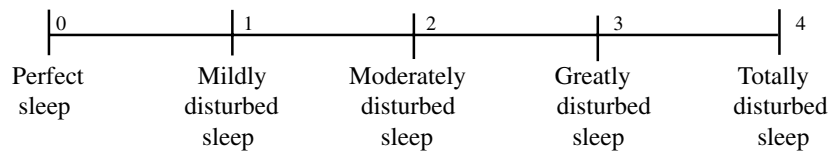
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

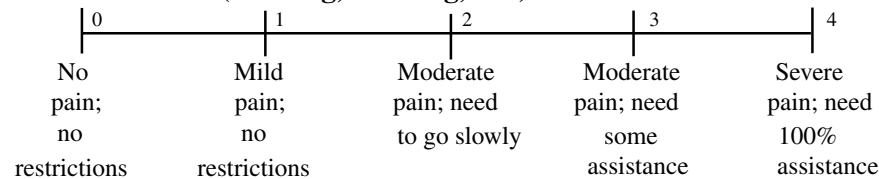
1. Pain Intensity



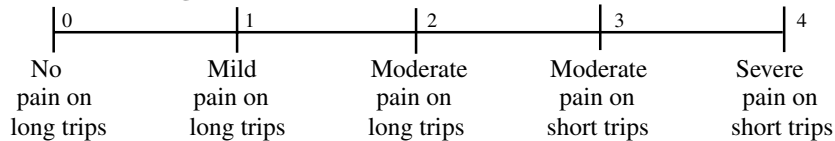
2. Sleeping



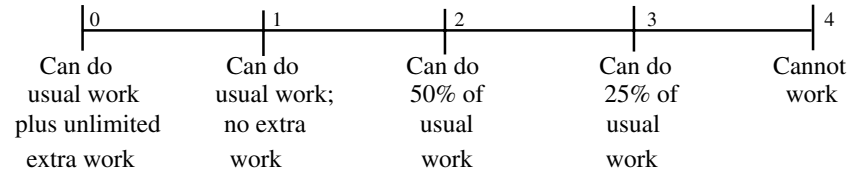
3. Personal Care (washing, dressing, etc.)



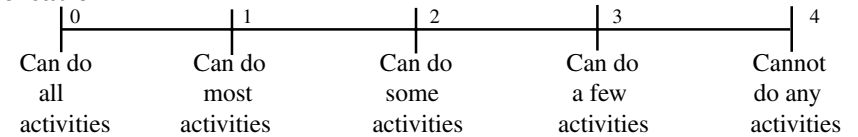
4. Travel (driving, etc.)



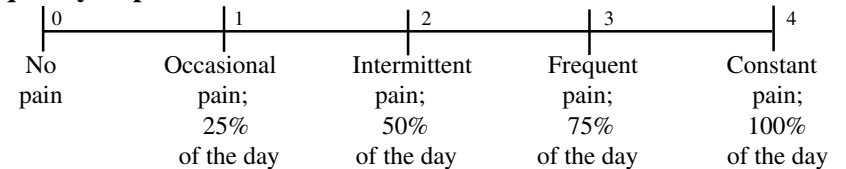
5. Work



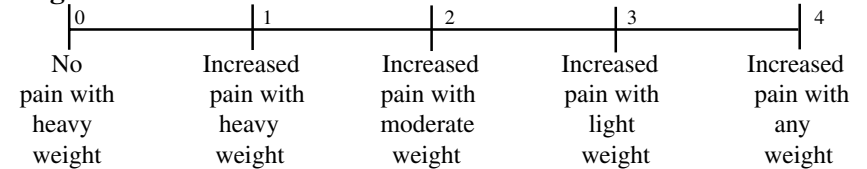
6. Recreation



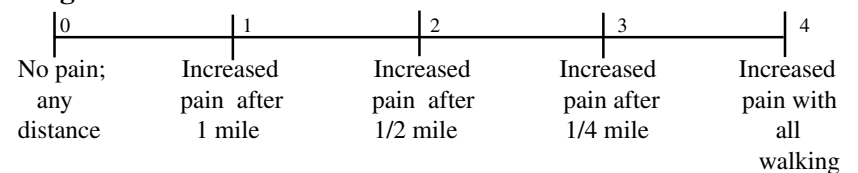
7. Frequency of pain



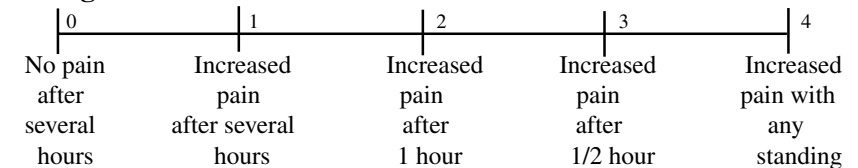
8. Lifting



9. Walking



10. Standing



Name _____

PRINTED

Signature

Total Score _____

Date

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.



LEVITAN
CHIROPRACTIC

Dr. Mark Levitan
406 Larkfield Road
East Northport, NY 11731
631-722-1722
Fax: 631-352-2527
Email: info@levitanchiropractic.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____, acknowledge and agree that I have received a copy of Levitan Chiropractic'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