Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent/Guardian Name(s):

Street Address: City: State: Zip:

Cell Phone: - - Home Phone: - - Work Phone: - -

Email: Child's SS #: - - Birthdate: / / Age:

How did you hear about us? Height: ft. in. Weight: lbs.

Who is your primary care physician?

Is your child receiving care from any other health professionals? ◯ Yes ◯ No
- If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs/other that your child is taking:

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Has your child ever received care for this condition before? ◯ Yes ◯ No
- If yes, please explain:

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

What makes the problem better? What makes the problem worse?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

◯ Resolve existing condition
◯ 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:

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? ◯ Yes ◯ No If yes, please explain: _____

Did mother smoke? ◯ Yes ◯ No If yes, how many per week? _____

Did mother drink? ◯ Yes ◯ No If yes, how many per week? _____

Did mother exercise? ◯ Yes ◯ No If yes, please explain: _____

Was mother ill? ◯ Yes ◯ No If yes, please explain: _____

Any ultrasounds? ◯ Yes ◯ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section At how many week's was your child born?

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other: Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

Child's birth weight: lbs. oz. Child's birth height: in. APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
- If yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____
Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
- If yes, please list any vaccination reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
- If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No If yes, please explain:

Behavioral, social or emotional issues? ◯ Yes ◯ No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

ACKNOWLEDGEMENT & CONSENT

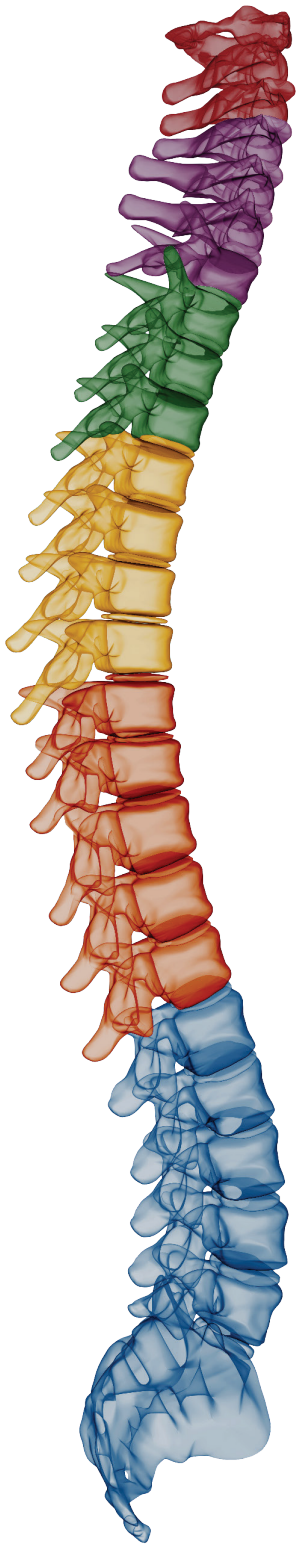
Patient Signature: _____ Date: _____

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

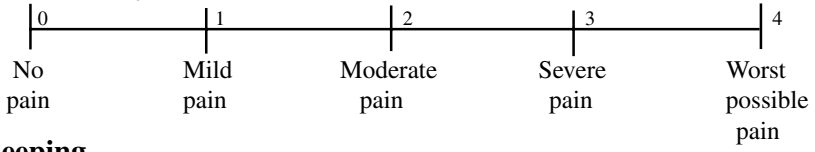
Patient Name: _____ Date: _____

Functional Rating Index

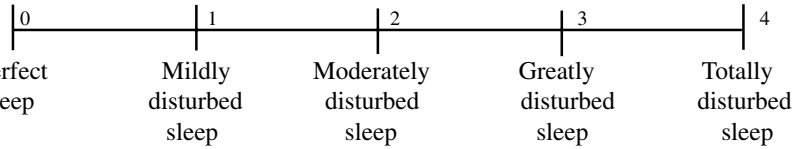
For use with **Neck and/or Back Problems** only.

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.**

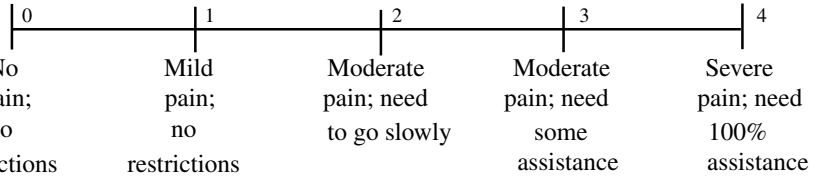
1. Pain Intensity



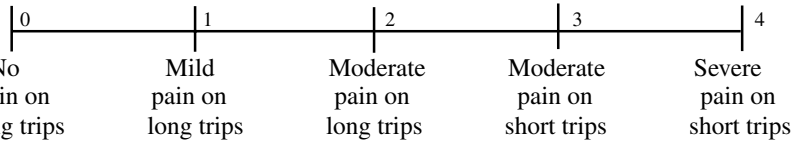
2. Sleeping



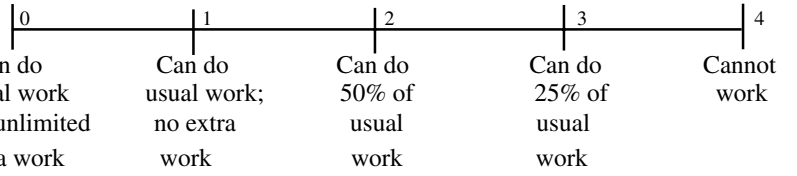
3. Personal Care (washing, dressing, etc.)



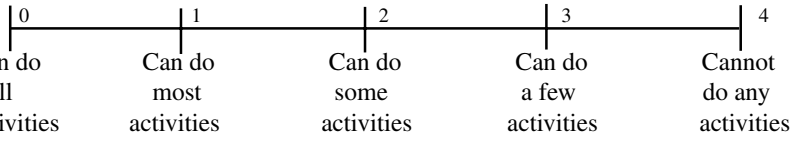
4. Travel (driving, etc.)



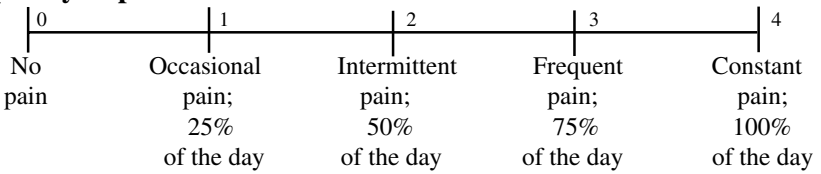
5. Work



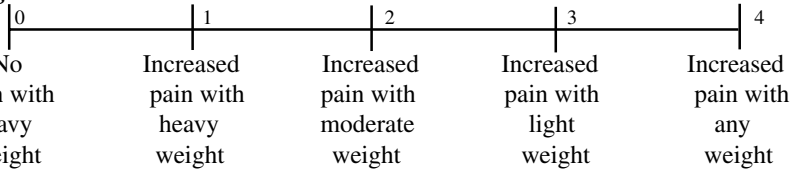
6. Recreation



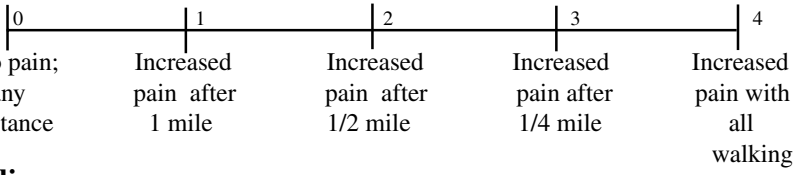
7. Frequency of pain



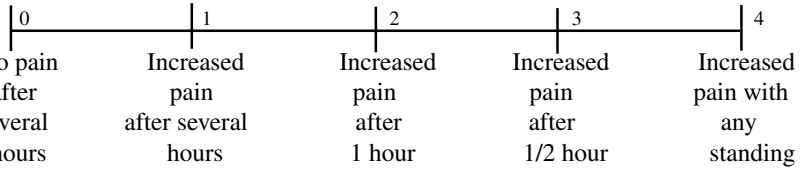
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

_____
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

LEVITAN CHIROPRACTIC

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

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize MARK J. LEVITAN, D.C. and whomever they may designate as assistants to provide Chiropractic services as deemed necessary to

my _____ (indicate relationship of child),

_____
(Print Name of Child)

Signed: _____ Date _____
(Signature of Parent or Guardian)

_____
(Print Name of Parent of Guardian)

Witnessed: _____
(Signature of Witness)

_____
(Print Name of Witness)