

*Welcome to Dr. J. J. Levine's office. Prepare for health!*

Last Name: _____	First Name: _____	M.I.: _____
Street: _____	Apt. #: _____	
City: _____	State: _____	Zip Code: _____
Email (for our office use only): _____		
Home Phone: (____) _____ - _____	Work Phone: (____) _____ - _____	ext. _____
Cell phone: (____) _____ - _____	Fax Line: (____) _____ - _____	
Birth date: __/__/__	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SSN: ____ - ____ - ____
Height _____		Weight _____
<input type="checkbox"/> If married, spouse's name: _____ & spouse's birth date: ____/____/____		
Emergency contact's name: _____		
Relationship to patient: _____		
Emergency contact's home: (____) _____ - _____ and their cell: (____) _____ - _____		
# of children: ____ Names and ages: _____		
How did you hear of us, or whom may we thank for referring you? _____		

Have you had an accident (major or minor) within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type of accident? <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other: _____
If yes, what date & time did this accident occur? ____/____/____ ____:____ am pm
If you are seeking care due to an accident it is possible care may be provided at no out of pocket cost to you. If seeking care due to an injury please ask the receptionist for the "accident questionnaire" at this time.
<input type="checkbox"/> I am <input type="checkbox"/> I am not seeking care due to an auto or work injury Initial here _____

Do you have health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a secondary insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide the receptionist with your insurance card(s) <u>now</u> . She will make a photocopy and our office will inform you of your coverage. Most insurance companies <u>cover</u> our services.
Primary insured's name: _____ their SSN ____ - ____ - ____ & birth date ____/____/____
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
Your marital status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Legally Separated
Your student status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Non-student
Your employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired
Your employer: _____ Spouse's employer, if married: _____
I realize my health insurance company will be billed as a service to me. Until my benefits can be verified, I will be responsible for payment of care today. If I have coverage, the amount I pay today will be applied to my deductible and/or my daily co-insurance payments. If I do not have coverage the doctor will discuss an affordable plan with me. I may also be asked to help pursue the insurance company in small claims court if necessary.
Initial here _____

Your initial visit today will include an extended evaluation with Dr. J. J. Levine. If necessary, x-rays will be taken. The fee for today's visit is \$100.00. I will pay with: <input type="checkbox"/> Cash <input type="checkbox"/> Credit card <input type="checkbox"/> Check
Signature _____ Today's date ____/____/____

## Health History Questionnaire

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

What name do you prefer to go by? \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Are you pregnant?  n/a (male)  No  Unsure  Yes, due date \_\_\_/\_\_\_/\_\_\_

X-rays taken w/in the last year?  No  Yes date \_\_\_/\_\_\_/\_\_\_ Reason \_\_\_\_\_

Doctor's name & phone where x-rays were taken: \_\_\_\_\_

List medications, vitamins, birth control: \_\_\_\_\_

List allergies: \_\_\_\_\_ List fractured bones: \_\_\_\_\_

List surgeries & organs removed: \_\_\_\_\_

Do you have any concerns about chiropractic care?  No  Yes, \_\_\_\_\_

Do you have any concerns about therapy/rehabilitation?  No  Yes, \_\_\_\_\_

### **Description of your Current Chief Complaint**

Are you here for:  a checkup  a specific problem

What is your #1 specific chief complaint? \_\_\_\_\_

What date did your chief complaint begin? \_\_\_/\_\_\_/\_\_\_ \_\_\_\_\_

What were you doing when this pain first appeared? \_\_\_\_\_

Have you had this problem before?  No  Yes explain \_\_\_\_\_

Where specifically is your chief complaint located? \_\_\_\_\_

Is your pain:  constant  comes and goes  other \_\_\_\_\_

What activities make your chief complaint better? \_\_\_\_\_

What activities make your chief complaint worse? \_\_\_\_\_

What position relieves this pain? \_\_\_\_\_

How often is your problem present  0-25%  26-50%  51-75%  76-100%

Does pain interfere w/ work/living habits?  No  Yes, how \_\_\_\_\_

What have you done for the pain yourself? \_\_\_\_\_

Check each box that describes **the chief complaint** you discussed above:  dull  
 sharp pain  numbness  tingling  stiffness  throbbing  aching  shooting  
 burning  cramping  radiating pain from \_\_\_\_\_ to \_\_\_\_\_  
 swelling  redness  other \_\_\_\_\_

Circle your pain level on this pain scale 0 = no pain ....up to.... 10 = intolerable pain  
no pain 0... 1 2 3 4 5 6 7 8 9 ...10 intolerable pain

Does your **chief complaint/pain** become worse at night?  Yes  No

It is better in the:  AM  MIDDAY  PM  Never lessens

It is worse in the:  AM  MIDDAY  PM  It is constant

Does your chief complaint interfere with your sleep?  Yes  No

By signing below, I certify the above information is complete and accurate to the best of my knowledge. Inaccurate information could be dangerous to my health.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Today's initial consultation date

**Health History Questionnaire Page 2**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Have you consulted/received other treatment for your chief complaint/condition?

No  Yes If yes, what treatments? \_\_\_\_\_

Name & phone of treating Dr. \_\_\_\_\_

Doctor's/care giver's specialty? \_\_\_\_\_

Result of treatment, did it help you?  Yes  No \_\_\_\_\_

List any major or minor accidents/trauma  fall  auto  sport  other Describe & list dates: \_\_\_\_\_

In addition to the chief complaint you described on page 1, do you have any **other problems or pain** you would like to address? Please list them in order of importance: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

- Check all that apply to you:**
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Colds   | <input type="checkbox"/> Loss of energy  | <input type="checkbox"/> Digestive trouble         |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Asthma/lungs weak         |
| <input type="checkbox"/> Ringing in ears                                   | <input type="checkbox"/> Hip pain        | <input type="checkbox"/> Hearing problems          |
| <input type="checkbox"/> Mid back pain                                     | <input type="checkbox"/> Cramps          | <input type="checkbox"/> Neck pain                 |
| <input type="checkbox"/> Nervousness                                       | <input type="checkbox"/> Low back pain   | <input type="checkbox"/> Trauma _____              |
| <input type="checkbox"/> Prostate issues                                   | <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Low blood pressure        |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Heart disease   | <input type="checkbox"/> High blood pressure       |
| <input type="checkbox"/> Sore throats                                      | <input type="checkbox"/> Tonsillitis     | <input type="checkbox"/> Gall bladder issues       |
| <input type="checkbox"/> Cancer/tumor                                      | <input type="checkbox"/> HIV/AIDS        | <input type="checkbox"/> Kidney problems           |
| <input type="checkbox"/> Aortic aneurysm                                   | <input type="checkbox"/> Osteoporosis    | <input type="checkbox"/> Abnormal weight loss/gain |
| <input type="checkbox"/> Stroke: date ____/____/____                       | <input type="checkbox"/> Leg pain/cramps | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Back/spinal condition or disorder describe: _____ |  |  |

- Check all that apply to your family history:  Osteoporosis  Stroke  Seizures  
 Cancer  Diabetes  Abnormal blood pressure  Cardiovascular disease

**Dr. J.J. Levine's Mission**

Your nervous system is made up of your brain, spinal cord & nerves. Your nervous system is in charge of directing, controlling, & coordinating every organ & system in your body. If you have a misaligned spinal bone, the nerves exiting through that spinal bone are not operating at their best. I detect this, then gently & manually perform spinal adjustments to remove spinal cord interference (Subluxations). Once adjusted the nerve tracts are no longer compressed & your nervous system can work at its optimum. Ultimately homeostasis & health are restored naturally to every organ, system, tissue & cell in your body. I have over six years of schooling in anatomy, physiology, the central nervous system, etc. I have had the honor of helping thousands of patients & their families, here in Tempe, since 1991. I do not diagnose nor claim to cure disease. Instead, I choose to assist your body's inborn (innate) healing ability to occur on its own. By signing below I consent to care as explained and I certify my information above is complete & accurate.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Today's date

**Health Care Authorization Form (HIPPA Privacy Practices)**

**Here at Dr. J. J. Levine's office we ask you for a few specific authorizations**

All information you provide to us is confidential in nature and will only be referenced when contacting you, the insurance company, or another relative facility. By signing this form I give permission to **Dr. Jonathan J. Levine's Office** to use all information I provide, as this office deems appropriate.

By signing below I give this office permission to:  
Send me birthday cards, holiday-related cards, and thank you cards and gifts.  
Call me and/or leave messages for me on an answering machine.  
Provide me information on treatment and other health related information.  
Allow staff and other patients to view my name on the sign in register.  
When I refer another patient, list my name in the monthly newsletter for recognition.  
Take my picture for the "well adjusted patients" bulletin board that is inside the office.  
Treat me in a semi-open room where others may see me if passing by in the hall.  
File a health care provider lien to bind insurance companies to forward payment.  
Display any testimonial I may write in order to share my success with others.

I am aware other persons in this office may overhear my protected health information during the course of care. I also understand my information may be overheard by other patient's at the front desk or in other areas of the office. Should I need to speak with the doctor privately at any time, the doctor will provide a room for these conversations.

By signing this form I am giving **Dr. Jonathan J. Levine's Office** permission to use and disclose my private protected information in accordance with the directives listed above.

**Acknowledgement of Receipt of Notice Of Privacy Practices**

Please feel free to read the binder located on the front reception counter. I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges:  
I have the right to review the notice prior to signing this consent.  
I have the right to object to the use of my health information for directory purposes.  
I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

This authorization shall expire on the following date: No expiration date

**The patient identified below authorizes Dr. Jonathan J. Levine's Office to use & disclose protected health information in accordance with all items described.**

**Patient's signature:** \_\_\_\_\_

**Please print your name:** \_\_\_\_\_

**Patient's SSN:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_