

## WELCOME TO INNATE LIFE CENTER

Last Name: _____		First Name: _____		M.I.: _____	
What name do you prefer to go by? _____					
Address: _____				APT #: _____	
City: _____		State: _____		Zip Code: _____	
Email (for office use only): _____					
Home Phone: (____) _____			Work Phone: (____) _____ EXT _____		
Cell Phone: (____) _____			Fax Line: (____) _____		
Date of Birth: ____/____/____		Sex: <input type="checkbox"/> M <input type="checkbox"/> F		SSN: _____	
		Height _____		Weight _____	
Spouse's name: _____				Phone: (____) _____	
<b>Emergency contact other than Spouse:</b>					
Name: _____			Relation: _____		
Home Phone: (____) _____			Cell Phone: (____) _____		
How did you hear about us/whom may we thank for referring you? _____					

Have you had an accident (major or minor) within the past 2 years? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If yes, what type of accident? <input type="checkbox"/> AUTO <input type="checkbox"/> WORK <input type="checkbox"/> OTHER: _____	
If yes, what date and time did this accident occur? ____/____/____ :____ am pm	
<i>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 front desk for the "accident questionnaire" at the time.</i>	
Are you seeking care due to an auto of work injury? <input type="checkbox"/> NO <input type="checkbox"/> YES Initial Here: _____	

Do you have primary health insurance policy? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Do you have a secondary health insurance policy? <input type="checkbox"/> NO <input type="checkbox"/> YES	
<i>If yes, please provide the front desk with your health insurance card(s) at this time and our office will inform you of your coverage. <b>Most insurance companies cover our services.</b></i>	
Policy Holder's Name: _____ Date of Birth: ____/____/____ SSN: _____	
Relation to Policy Holder: <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: _____	
<b>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 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.</b>	
Initial Here: _____	

Your initial visit today will include an extended evaluation with Dr. Jonathan J. Levine, D.C. If necessary, x-rays will be taken. <b>The Fee for today's visit is \$100.00. I will pay with:</b>		
<input type="checkbox"/> CASH <input type="checkbox"/> CREDIT CARD <input type="checkbox"/> CHECK		
_____ Signature of Patient/Guardian	_____ Print Name	____/____/____ Date

# HEALTH HISTORY QUESTIONNAIRE

PATIENT'S FULL NAME: \_\_\_\_\_

Are you pregnant?  N/A (male)  No  Unsure  Yes, Due Date: \_\_\_/\_\_\_/\_\_\_

Have you had x-rays within the last year?  NO  YES If Yes, date: \_\_\_/\_\_\_/\_\_\_

Reason: \_\_\_\_\_

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

List any medications (including birth control) or vitamins you are currently taking:  
\_\_\_\_\_  
\_\_\_\_\_

List Allergies: \_\_\_\_\_

List Fractured Bones: \_\_\_\_\_

List Surgeries or Transplants: \_\_\_\_\_

List major/minor accidents trauma: \_\_\_\_\_

Do you have any concerns about chiropractic care?  NO  YES, \_\_\_\_\_

Do you have any concerns about therapy/rehabilitation?  NO  YES, \_\_\_\_\_

**Check all that apply:**

- Headaches                      Osteoporosis    Hearing Problems    Ringing in Ears
- Depression
- Neck Pain                      Sore Throats                      Aortic Aneurysm    Vision Problems                      Dizziness
- Shoulder Pain                      Nervousness                      Heart Disease                      Low Blood Pressure                      Trauma
- Upper Back Pain                      Seizures                      Kidney Problems                      High Blood Pressure                      Cold
- Mid-Back Pain                      Loss of Energy                      Cancer/tumor                      Digestive Trouble                      Diarrhea
- Low Back Pain                      Constipation                      Gall Bladder Issues                      Asthma/Weak lungs                      HIV/AIDS
- Hip Pain                      Cramps                      Prostate Issues                      Urinary Tract Infections                      Diabetes
- Leg Pain/Cramps                      Arthritis/rheumatism                      Difficulty Sleeping                      Stroke: date: \_\_\_/\_\_\_/\_\_\_                      Tonsillitis
- Back/Spinal Condition, please describe disorder: \_\_\_\_\_
- Abnormal weight gain/loss                       Other: \_\_\_\_\_

**Family Medical History: Please check all the apply**

- Cancer                       Stroke                       Seizures                       Diabetes                       Abnormal Blood Pressure
- Osteoporosis                       Cardiovascular Disease

**Current Chief Complaint:**

Are you here for: a  check up  a specific problem: \_\_\_\_\_

What were you doing when this complaint first appeared: \_\_\_\_\_

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

## HEALTH HISTORY QUESTIONNAIRE CONT'ed

Have you had this complaint before?  NO  YES, \_\_\_\_\_

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

Is your complaint:  Constant  Comes and Goes  Other: \_\_\_\_\_

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

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

What position relieves this complaint? \_\_\_\_\_

How often is your complaint present (please circle)? 0-25% 26-50% 51-75% 76-100%

Does this complaint interfere with work/living habits?  NO  YES, \_\_\_\_\_

What have you done for this complaint? \_\_\_\_\_

**Check each box that describes the chief complaint you discussed above:**

Dull Pain     Sharp Pain     Numbness     Tingling     Stiff     Throbbing     Aching  
 Shooting     Burning     Cramping     Swelling     Redness     Radiating: From: \_\_\_\_\_ to \_\_\_\_\_

Please circle your pain level on this scale: **0 = no pain...up to...10 =intolerable pain**

0      1      2      3      4      5      6      7      8      9      10

My complaint is:

**Better** in the: AM    MIDDAY    PM    Never Lessons

**Worse** in the: AM    MIDDAY    PM    Constant

Does your complaint interfere with your sleep?  NO  YES

Have you consulted/received other treatments for your chief complaint?  NO  YES

If yes, what treatments: \_\_\_\_\_

Result of treatments: \_\_\_\_\_

Name/ Phone number of treating doctor: \_\_\_\_\_

Treating doctor's specialty: \_\_\_\_\_

Are there any other problems/pains that you wish to address during this visit?     NO  YES

\_\_\_\_\_

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

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of Patient/Guardian

Print Name

Date

## HIPPA Health Care Authorization Form (Privacy Practices)

All information you provide us with is confidential in nature and will only be referenced or shared with you, insurance companies, providers and billing or legal facilities who provide us with a signed request. By signing this form I give permission to **Dr. Jonathan J. Levine, D.C.'s** Office to use all information I provide, as this office deems appropriate.

In addition, by signing below I give this office permission to:

- ❖ Send me correspondence and provide me with health & other related information.
- ❖ Call and/or leave messages for me on an answering machine and/or voicemail.
- ❖ Provide health care professionals & others with my information when requested.
- ❖ Allow staff and other patients to view my name on the sign in register/sheet.
- ❖ 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 testimonials I may write.
- ❖ Forward to/request my records from providers, attorneys & insurance companies.

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, D.C.'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 in 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, D.C.'s Office to use and disclose protected health information in accordance with all items described.

Print Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient/Guardian      Print Guardian Name, *if applicable*      Date

