Levinson Chiropractic Center
5457 Roswell Road, Suite 102
Atlanta, GA 30342
404.257.0404
Fax: 404.257.0351

Thank you for choosing Levinson Chiropractic & VAX-D Center. Attached you will find a copy of our New Patient Packet. Please fill out all of the paper work as best as you can, and sign by all of the X's. If you have any questions, or concerns please call our office at 404-257-0404.

When you have completed the paperwork, please *fax* it back to us (do not send it in e-mail as we cannot accept e-mails with attachments), along with a *copy of your driver's license and your major medical insurance card, front and back. Our fax number is 404-257-0351*

We look forward to meeting with you. Please arrive to your appointment 15 minutes early so that we may process your paperwork. Please note that this time has been reserved specifically for you. *If for any reason you are unable to make this appointment it is important that you call us, so that we may reserve this time for someone else.*

Yours in Health,

Levinson Chiropractic Center
Backworx Treatment Center

DATE	I.D. NO.

PERSONAL HISTORY

E-mail Address: ________________________________

Name: ____ Address: ______________________________________

City: ____ State: ___________________ Zip: _____________

Home Phone: ___________________________________ Cell Phone: ____________________________________

Date of Birth: ________________ Age: _______ Sex: ___ M ___ F

Social Security Number: _________________________ Driver's License Number: ________________________

Business/Employer: _____________________________ Type of Work: _________________________________

Business Phone: ________________ Circle One: Married Single Widowed Divorced Separated No. of Children: __

Name of Spouse: _______________________________ Spouse's Social Security Number: _________________

Spouse's Drivers License Number: __________________ Spouse's Employer: ____________________________

Business Phone: _________________________________ Type of Work: _________________________________

Name & Number of Emergency Contact: _____________________________________ Relationship: _______________

Referred To This Office By: ____

Who is responsible for your bill: (Circle One) Self Spouse Workman's Comp Auto Insurance
Medicare Medicaid Personal Health Insurance

CURRENT HEALTH CONDITION

Purpose of this appointment: ____

Other doctors seen for this condition: YES NO Who? ____

Type of Treatment: ______________________________ Results: _______________________________________

When did this condition begin: _____________________ Has this condition occurred before? YES NO

Is condition: ______ Job Related _____ Auto Related _____ Home Injury _____ Fall Other __________________

Date of Accident: ________________________________ Time of Accident: _______________________________

Have you made a report of your accident to your employer: ______ Yes ______ No

Drugs you take now: _____ Nerve Pills ______ Pain Killers/Muscle Relaxers ______ Blood Pressure Medicine
_____ Insulin ______ Other: ____

Do you wear a shoe lift? _____ Yes ______No

Do you suffer from any condition other than that which you are now consulting us? ____________________________

____

PAST HEALTH HISTORY

Please check or describe:

Major Surgery/Operations: ______ Appendectomy ______ Tonsillectomy ______Gall Bladder ______Hernia
______ Back Surgery ______ Broken Bones ______ Other ________________________

Major Accidents or Falls: ____

____

Hospitalization (other than above) ____

____

Previous Chiropractic Care: ______ None ______ Doctor's Name and Approximate Date of Last Visit: ______________

____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted

for care. Please enter a check mark in front of all the following signs and symptoms. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS

___ Headache
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Dizziness
___ Convulsions
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Loss of Weight
___ Numbness or Pain in arms/Legs/hands
___ Allergy (what)
___ Wheezing
___ Neuralgia

GASTRO-INTESTINAL

___ Poor appetite
___ Poor Digestion
___ Excessive Hunger
___ Belching or Gas
___ Nausea
___ Vomiting
___ Vomiting Blood
___ Pain Over Stomach
___ Constipation
___ Diarrhea
___ Colon Trouble
___ Hemorrhoids (piles)
___ Liver Trouble
___ Jaundice
___ Gall Bladder Trouble

EYE/EAR/NOSE/THROAT

___ Poor Vision
___ Crossed Eyes
___ Pain in Eyes
___ Deafness
___ Earache
___ Ear Noises
___ Ear Discharges
___ Nasal Obstruction
___ Nose Bleeds
___ Sore Throat
___ Hoarseness
___ Hay Fever
___ Asthma
___ Frequent Colds
___ Enlarged Thyroid
___ Tonsillitis
___ Sinus Trouble

RESPIRATORY

___ Chronic Cough
___ Spitting Blood
___ Spitting Phlegm
___ Chest Pain
___ Difficulty Breathing

GENITO-URINARY

___ Frequent Urination
___ Painful Urination
___ Blood in Urine
___ Kidney Infection
___ Bed Wetting
___ Inability to Control Urine
___ Prostate Trouble

MUSCLE & JOINTS

___ Weakness
___ Twitching
___ Stiff Neck
___ Backache
___ Swollen Joints
___ Tremors
___ Foot Troubles
___ Painful Tailbone
___ Pain Between Shoulders
___ Hernia
___ Spinal Curvature
___ Low Back Pain

CARDIO-VASCULAR

___ Rapid Heart
___ Slow Heart
___ High Blood Pressure
___ Low Blood Pressure
___ Pain Over Heart
___ Prev. Heart Trouble
___ Swelling of Ankles
___ Poor Circulation
___ Varicose Veins
___ Strokes

SKIN/ALERGIES

___ Skin Eruptions
___ Itching
___ Bruising Easily
___ Dryness
___ Boils
___ Sensitive Skin
___ Hives/Allergies
___ Eczema
___ Medicines

FOR WOMEN ONLY

___ Painful Periods
___ Excessive Flow
___ Irregular Cycles
___ Hot Flashes
___ Cramps/Backache
___ Miscarriage
___ Vaginal Discharge
___ Pregnant at this time
___ Last Pap

By Who: ____________________
Other: ______________________
____

HABITS

___ Smoking ___ pks/day _____
___ Drinking ___ alcohol ______
___ Coffee ___ cups/day ____

EXERCISE

___ None
___ Moderate
___ Daily

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	_____	_____	_____	______	______
Father	_____	_____	_____	______	______
Brother No of ___	_____	_____	_____	______	______
Sister No of ___	_____	_____	_____	______	______

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

___ Appendicitis
___ Pneumonia
___ Rheumatic Fever
___ Polio
___ Tuberculosis
___ Whooping Cough

___ Anemia
___ Measles
___ Mumps
___ Chicken Pox
___ Diabetes
___ Cancer

___ Heart Disease
___ Goiter
___ Influenza
___ Pleurisy
___ Alcoholism
___ Veneral Infection

___ Arthritis
___ Epilepsy
___ Mental Disorder
___ Lumbago
___ Eczema
___ AIDS

DO NOT WRITE BELOW THIS LINE

Diagnosis:

Patient Accepted? ( ) Yes ( ) No ( ) Referred

____
Doctor's Signature

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms

corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

[ ] Relief Care [ ] Corrective Care [ ] Comprehensive Care [ ] Check here if you want the Doctor to select the type of care appropriate for your condition.

___________________ X____
Date Patient Signature

If this is an accident related injury, please fill out the Accident Form. Thank you!

THE PURPOSE OF
OUR CHIROPRACTIC CENTER
IS TO SUPPORT
EACH INDIVIDUAL
IN ACHIEVING THEIR
OPTIMUM HEALTH

AND TO
EDUCATE THEM
SO THAT THEY MAY
UNDERSTAND HEALTH
AND CHIROPRACTIC
AND IN TURN EDUCATE OTHERS.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare an necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I herby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid to the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient is of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature X____ Date __________________

Guardian or Spouse's
Signature Authorizing Care ____ Date __________________

X **NAME: ________________________**

X DATE: ______________________

PLEASE FILL OUT THIS PORTION OF THE PAPERWORK, THIS WILL HELP DETERMINE YOUR CARE.

SF – 36™ Health Evaluation

Acute US Version 1.0

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INSTRUCTIONS: This evaluation asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

1) In general, would you say your health is: (Circle One)

Excellent ………… ………… ………… ………… ………… ……1
Very Good ………… ………… ………… ………… ………… ……2
Good ………… ………… ………… ………… ………… ……3
Fair ………… ………… ………… ………… ………… ……4
Poor ………… ……… ………… ……… ………… ……5

2) Compared to one week ago, how would you rate your health in general *now*? (Circle One)

Much better than one week ago ………… ………… ………… ……1
Somewhat better now than one week ago ………… ………… ……2
About the same as one week ago ………… ………… ………… ……3
Somewhat worse than one week ago ………… ………… ……4
Much worse now than one week ago ………… ………… ……5

3) The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Circle One Number on Each Line)

Activities	Yes, Limited A Lot		Yes, Limited A Little		No, Not Limited At All
a) Vigorous Activities, such as running, lifting heavy objects, participating in strenuous sports.	1		2		3
b) Moderate Activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf.	1		2		3
c) Lifting or carrying groceries.	1		2		3
d) Climbing several flights of stairs.	1		2		3
e) Climbing one flight of stairs.	1		2		3
f) Bending, kneeling, or stooping.	1		2		3
g) Walking more than a mile.	1		2		3
h) Walking several blocks.	1		2		3
i) Walking one block.	1		2		3
j) Bathing or dressing yourself.	1		2		3

4) During the past week, have you had any of the following problems with your work or other regular

daily activities <u>as a result of your physical health</u>? (Circle Yes or No)

a) Cut down on the amount of time you spent on work or other activities?	YES	NO
b) Accomplished less than you would like?	YES	NO
c) Were limited in the kind of work or other activities?	YES	NO
d) Had difficulty performing the work or other activities? (for example, it took extra effort).	YES	NO

5) During the <u>past week,</u> have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)? (Circle Yes Or No)

a) Cut down on the amount of time you spent on work or other activities?	YES	NO
b) Accomplished less than you would like?	YES	NO
c) Didn't do work or other activities as carefully as usual?	YES	NO

6) During the past week, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups? (Circle One)

Not At All ……… ………… ………… ………… ………… ………… ……1
Slightly ……… ………… ………… ………… ………… ………… ……2
Quite A Bit ……… ………… ………… ………… ………… ………… ……3
Extremely ……… ………… ………… ………… ………… ………… ……4

7) How much <u>bodily pain</u> have you had during the <u>past week</u>? (Circle One)

None ……… ………… ………… ………… ………… ………… ……1
Very Mild ……… ………… ………… ………… ………… ………… ……2
Mild ……… ………… ………… ………… ………… ………… ……3
Moderate ……… ………… ………… ………… ………… ………… ……4
Severe ……… ………… ………… ………… ………… ………… ……5
Very Severe ……… ………… ………… ………… ………… ………… ……6

8) During the <u>past week,</u> how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle One)

Not At All ……… ………… ………… ………… ………… ………… ……1
A Little Bit ……… ………… ………… ………… ………… ………… ……2
Moderately ……… ………… ………… ………… ………… ………… ……3
Quite A Bit ……… ………… ………… ………… ………… ………… ……4
Extremely ……… ………… ………… ………… ………… ………… ……5

9) These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling.

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a) Did you feel full of pep?		1	2	3	4	5	6
b) Have you been a very nervous person?		1	2	3	4	5	6
c) Have you felt so down in the dumps that nothing could cheer you up?		1	2	3	4	5	6
d) Have you felt calm and peaceful?		1	2	3	4	5	6
e) Did you have a lot of energy?		1	2	3	4	5	6
f) Have you felt downhearted and blue?		1	2	3	4	5	6
g) Did you feel worn down?		1	2	3	4	5	6
h) Have you been a happy person?		1	2	3	4	5	6
i) Did you feel tired?		1	2	3	4	5	6

10) During the past week, how much of the time has your physical health or emotional problems interfered with your social activities? (ex. Visiting with friends, relatives, ect.) (Circle One)

All of the time ……… ………… ………… ………… ………… ………… ……1
Most of the time …… ………… ………… ………… ………… ………… ……2
Some of the time …… ………… ………… ………… ………… ………… ……3
A little of the time … ………… ………… ………… ………… ………… ……4
None of the time …… ………… ………… ………… ………… ………… ……5

11) How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a) I seem to get sick a little easier than	1	2	3	4	5

*** * We need a copy of your driver's license and insurance card for our records * ***

As a courtesy to you, we will bill your insurance company on a weekly basis. If a payment is not received after 60 days, you should contact your insurance company and have them make the payment. If, after 90 days, payment is still not received, you will be asked to make payment. The below signed authorization is needed or we can not submit your claims directly to your insurance company. **In any case where your insurance company sends payment directly to you, realize this is done in error and call our office immediately so that we may follow the correct protocol for payment to reach our office.**
"I authorize the Levinson Chiropractic Center to release medical information or any information pertaining to the examination, treatment, history and medical expenses to my insurance company(ies) for the purpose of processing insurance claims"

X Insured Name: ______________________________
X Signature: ______________________________ Date: ______________________________

For Office Use Only

Insurance Company Name: ______________________________
Insurance Company Phone#: ______________________________
Policy #: ______________________________
Group #: ______________________________
Policy Holder: ______________________________
D.O.B./SS#/Zip Code: ______________________________

Verification

Date of Call: ______________ Time of Call: __________ Contact Person: ______________________________
Chiropractic Coverage: Yes:______ No:______ HMO/PPO/POS/Other ______________________
Effective Date _____________ Yearlly? ______________
Is Precertification Required? Yes:______ No:______ Details: ______________________________

IN NETWORK				**OUT NETWORK**			
Deductible:	__________	Used?	________	Deductible:	__________	Used?	________
		Carryover?	________			Carryover?	________
Coverage %:	__________			Coverage %:	__________		
Co-pay:	__________			Co-pay:	__________		
# Visits/year:	__________	Used:	________	# Visits/year:	__________	Used:	________
Max $ per year	__________	Used:	________	Max $ per year	__________	Used:	________
Out of Pocket, I:	__________	F:	________	Out of Pocket, I:	__________	F:	________

Claims Address: ______________________________
____
____

Other Coverage Informaton:
Massage Therapy: ____________
Supplies/Pillows/Supports: ____________
Orthotics: ____________
Other information: ____________________
____
____