Innovative Alternative Medicine
Dr. Robert Levingston DC, FIAMA

New Patient Intake Form

Patient Data **Date**_____

Title: (Circle one) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Dr. ☐ **Date of Birth** _____/_____/_____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____ **City** _____ **State**____ **Zip Code** _____

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Cell Phone (____) _____-_____ **Email** _____

Sex:☐ Male Female **Marital Status:** ☐ Single ☐ Married ☐

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other____

Employer Data

Name _____ **Occupation** _____ **Job Description** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Emergency Contact

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____

How did you hear about our office?

_____

Have you been to a Chiropractor in the past? If so, what for?

_____

_____

Who is your Primary Care Physician? When was your last visit?

_____

_____

Pain Level: Now

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Severe Pain

Pain Level: On a Good Day

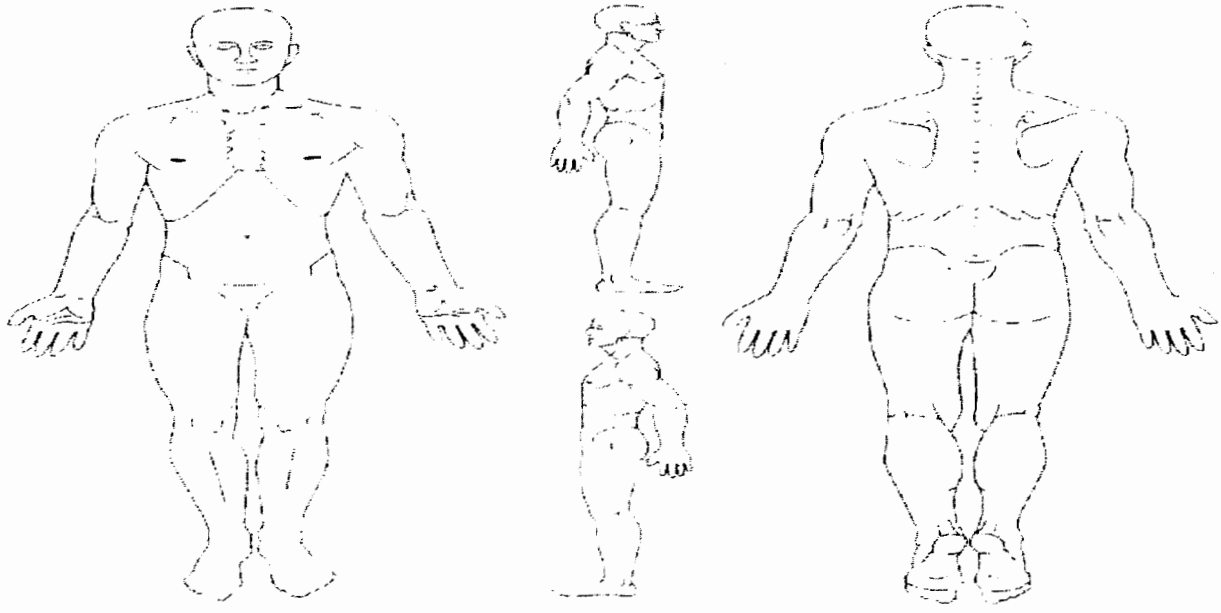
0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Severe Pain

Pain Level: On a Bad Day

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Severe Pain

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B=Burning** **S=Stabbing** **T=Tingling** **A=Dull Ache**



Describe your symptoms in order of severity, with worse symptom being #1: _____

_____

_____

_____

When did your symptoms begin? **Month**_____ **Day**_____**Year** _____

Are your symptoms a result of: ___Motor Vehicle Accident ____Work related Accident _____Other

How did your symptoms begin? _____

_____

_____

What treatments have you tried for your symptoms?

_____

_____

_____

_____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day)
☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day)
☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐ Sharp
☐ Dull ache
☐ Numb
☐ Shooting
☐ Burning
☐ Tingling
☐ Stabbing
☐ Other _____

How are your symptoms changing?
☐ Getting better ☐ Not changing ☐ Getting worse

Employment, ADL, and Recreation Information

Description of Work: _____

Condition's Effect on Job Performance: ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability) ☐ **Mod/Sev** (limited duty) ☐ **Sev** (no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke
☐ Headaches	☐ Multiple Sclerosis	☐ Epilepsy	☐ GI
☐ Urinary	☐ Ears Nose Throat	☐ Back	☐ Neck

☐ Other _____

Past Medical History:

_____

_____

_____

Surgeries: (Please list ALL surgeries hospitalizations)

_____

_____

Accidents/ Traumas:(List any significant traumas you have had in your lifetime

_____

_____

Allergies: _____

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Cigarettes:	☐<1 pack/day	☐ >1 pack/day	☐ never

Family History: (Check all that apply)

Arthritis:	☐ Parent	☐ Sibling
Cancer:	☐ Parent	☐ Sibling
Diabetes:	☐ Parent	☐ Sibling
Heart Disease	☐ Parent	☐ Sibling
Hypertension	☐ Parent	☐ Sibling
Stroke	☐ Parent	☐ Sibling
Thyroid	☐ Parent	☐ Sibling

Other _____

Current Medications/Vitamins:_____

_____

Are you pregnant? Yes_____ No _____N/A_____

The statements on this form are correct to the best of my recollection. I understand that I am financially responsible for all charges. I understand that Dr. Levingston does not bill insurance and payment is due at the time of service.

Signature: _____ Date: _____

Rev 12/12

HIPAA Policies & Procedures
Office Personnel
For Specialized Governmental Functions
□ We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Correctional Institutions
□ If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors
□ We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses
□ Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization. You may revoke any authorization at any time, as previously provided in this Notice under "Your Health Information Rights."

Website
□ If we maintain a website that provides information about our entity, you will be able to access our Notice electronically on our website.

PATIENT SIGNATURE SECTION:

Acknowledgement of Receipt of Notice of Privacy Practices:
I acknowledge that I have received the attached (above) Notice of Privacy Practices ("The Notice") for the practice of Dr. Levingston DC, FIAMA.

_____
Print Name

_____ _____
Patient (or Patient Representative*) Signature Date
****If Patient Representative, legal documentation must be included to show authority to sign or receive information.*

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some inherent risks that may be associated with chiropractic or acupuncture treatment, including, but not limited to:

- While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
- There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well-being.

The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I will have the opportunity to discuss the following with my healthcare provider:

a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment; and
d. Any alternatives to that treatment.

I will have the opportunity to ask questions and receive answers regarding the treatment.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding that outcome of these procedures.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Dr. Levingston or other licensed doctors of chiropractic who now, or in the future, treat me while employed by, working for or serving as back-up for Dr. Levingston DC, FIAMA.

Patient Signature: _____ Date: _____

Or Patient Representative Signature: _____ Relationship: _____

Office Signature: _____ Date: _____