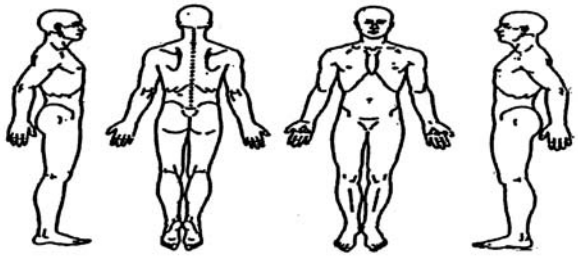
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Age _____
Occupation _____

16. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?

□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:_____				

20. List all prescription medications you are currently taking:

_____

21. List all of the over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?

_____

25. Have you ever been hospitalized? □ No □ Yes

if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

LUKOSAVICH CHIROPRACTIC CENTER
48881 HAYES R.D. ♦ SHELBY TOWNSHIP, MI 48315 ♦ 586.532.6373
WWW.LUKOSAVICHCHIRO.COM

NOTICE OF PRIVACY PRACTICES

Abridged Edition

Effective April 14, 2003 the Department of Health & Human Services has implemented protection for patient health care information. It outlines who we may disclose information to without your authorization and how we can disclose your protected health information with your authorization as well as how you can gain access to your personal health information or to make a complaint to the Department of Health & Human Services .if you feel your protected health information was used in an improper way. This notice will give you a brief description of our entire privacy practices.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

So that this office can treat you, receive payment for that treatment and run our health care operation, we may use your protected health information without your authorization to send to third party payers, administrators, etc.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

With your signed authorization we may make communications with you to promote products and services that may not be for a specific purpose of providing treatment advice. You have the right to revoke this authorization. Other permitted and required uses and disclosures that may be made without your authorization or opportunity to object- we may disclose to a member of your family, a relative, a close friend or other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also disclose your protected health information to an authorized public or private entity as required by law.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, SUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations:

- Required by law
- Health Oversight
- Legal Proceedings
- Research

You may inspect or obtain a copy of your protected health information for as long as we maintain the information unless protected by federal law.

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operation. Also you may request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care. Your request must be in writing and state specific restrictions requested and to whom it applies.

RIGHTS TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATION FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

You may request that you receive these communications from us at an alternative location or by alternative means than is normally provided to other patients.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION

You may request an amendment to your protected health information for as long as we maintain your protected health information. In certain cases we may deny your request for an amendment.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE

You have the right to receive an accounting if we receive a request for disclosure of information for purposes other than treatment, payment and health care operations.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to receive a complete copy of our privacy practices by paper or electronically.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to us or to the Secretary of Health & Human Services.

This notice was published and becomes effective January 1st 2004.

Patient Processing and Release Form

To provide testing services, the following must be completely filled out and signed.

Insurance Auto/Insurance WC Attorney Lien Cash

Referring Physician: _____

Patient Name:_____ SS #: _____
Address:_____
Street / City / State / Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Cell Phone Carrier: _____
DOB:_____ Sex: M F Marital Status: S M D W
Employer:_____
Address:_____
Street / City / State / Zip: _____
E-mail: _____ Referred by: _____
Ethnicity: (please circle) Hispanic or Latina * Not Hispanic or Latina
Race: (please circle) White * Pacific Islander * Black/African American
Amer. Indian/Alaskan Native * Asian * Two or more races

Primary Insurance: _____
Insured Name (if not patient):_____
Insured's DOB:_____
Mailing Address:_____
Policy:_____ Group #: _____
Date of Accident: _____ Claim#: _____

Secondary Insurance: _____
Mailing Address: _____
Telephone: _____
Policiy: _____

I authorize the following for all medical services rendered to me

1. Processing of all insurance forms by *Lukosavich Chiropractic Center*.
2. Release of all necessary information by *Lukosavich Chiropractic Center* for such processing.
3. Payment of all medical benefits directly to *Lukosavich Chiropractic Center* or their agents.
4. Appeal of insurance payments/denials at all levels.
5. A photocopy of this form may be used instead of the original.

_____ _____
Patient Signature Date

Note: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization For
Marc Lukosavich DC PC

Effective: 02/01/2006

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Marc Lukosavich DC PC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Marc Lukosavich DC PC…

Marc Lukosavich DC PC also uses protected health information for the following reasons: (you may opt out of the authorization). Special initial authorization is required and attached. Marketing: internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing material. _____ (Please initial)

In the course of providing care, providers will share either written or electronic patient information with other providers who are involved in the patient's care, as appropriate.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Marc Lukosavich DC PC

You can reach the Privacy Official at: Marc Lukosavich DC PC. 48881 Hayes rd., Shelby Twp., MI 48315, 583-532-6373. Hours available: A message may be left for our privacy official any time the clinic is open and your call will be returned in 7 business days. Your Email address: _____ _____ (you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____ Date: _____

****

Staff complete only if NO signature is obtained. If it is not possible to obtain the patient's acknowledgment, describe the good faith effort made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

- Patient refused to sign this acknowledgement even though the patient was asked to do so and the Patient was given the Notice of Privacy Practices.
- Other : _____

Staff Signature _____