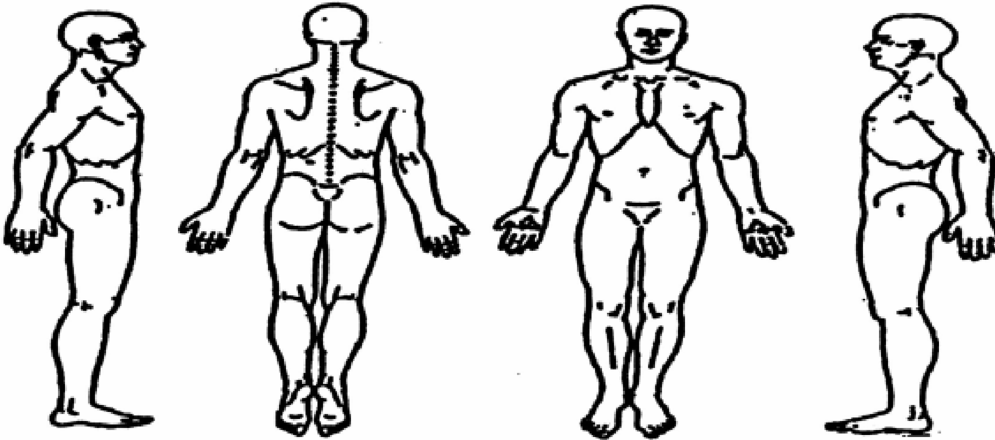
PATIENT INTAKE FORM

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** _____________Blood Presure____________________

Occupation ____

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, PC

Dr. Marc Lukosavich, DC
48881 Hayes Road
Shelby Township, MI 48315
Phone: 586-532-6373
Email: lukochiro@gmail.com

NOTICE OF PRIVACY PRACTICES (NPP)

Effective Date: February 16, 2026
For compliance with HIPAA and SUD record notice requirements (42 CFR Part 2)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

Lukosavich Chiropractic Center, PC is required by federal law (HIPAA) to:

- Maintain the privacy and confidentiality of your protected health information (PHI).
- Provide you this Notice of Privacy Practices explaining how your PHI may be used and disclosed.
- Follow the terms of this Notice as long as it remains in effect.
- Notify you if there is a breach of your unsecured PHI.

You have rights regarding your PHI as described below. We may update this Notice from time to time. If we materially change this Notice, a revised Notice will be available in our office and upon request.

HOW WE MAY USE & DISCLOSE YOUR HEALTH INFORMATION

1. Treatment

We may use and disclose PHI to provide, coordinate, and manage your chiropractic care.

2. Payment

We may use and disclose PHI to bill and collect for services, including submitting claims to insurers.

3. Health Care Operations

We may use PHI for internal activities such as quality assurance, staff training, licensing, and administrative operations.

4. Appointment Reminders & Health-Related Communications

We may contact you by phone, email, text, voicemail, or mail to remind you of appointments or inform you of options that might benefit your health.

Opt-Out Option: You may request not to receive such communications by contacting our office at 586-532-6373 or emailing **lukochiro@gmail.com**.

5. Individuals Involved in Your Care

With your permission, we may share relevant information with family or others involved in your care. If you are incapacitated, we may use professional judgment to determine if disclosure is in your best interest.

6. Required By Law

We may disclose PHI when required by law, including certain public health activities.

7. Law Enforcement & Legal Actions

We may disclose PHI when required by court order, subpoena, or in response to law enforcement requirements as permitted by law.

8. Business Associates

We may share PHI with service providers under contract (billing, record storage vendors) who are required to protect your PHI.

SUBSTANCE USE DISORDER (SUD) RECORDS & 42 CFR PART 2

Certain records related to substance use disorder (SUD) treatment are **protected under federal law (42 CFR Part 2)**.

Use and Disclosure of SUD Records

- SUD treatment records may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you **without your written consent or a court order**.

Limited Uses Without Consent

- Generally, SUD records require your written consent for uses or disclosures, even for treatment, payment, or healthcare operations, unless federal law authorizes otherwise.

Redisclosure

- Information disclosed under HIPAA or Part 2 protections may be subject to redisclosure by the recipient and may no longer be protected by HIPAA or Part 2.

Fundraising Communications

- SUD records may be used for fundraising only if you are given the opportunity to **opt out** of receiving such communications. To opt out, contact our office at 586-532-6373 or email **lukochiro@gmail.com**.

OTHER USES OF PHI

Uses and disclosures not described in this Notice will be made only with your written authorization. You may revoke an authorization at any time in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- **Right to Inspect and Copy:** Request to inspect or obtain a copy of PHI in hard copy or electronic form. Requests must be made in writing.
- **Right to Request Amendment:** Request amendments to your record if you believe information is incorrect or incomplete.
- **Right to an Accounting of Disclosures:** Request a list of certain disclosures of your PHI.
- **Right to Request Restrictions:** Request restrictions on uses and disclosures. We may agree or deny, except for certain SUD protections.
- **Right to Confidential Communications:** Request communications by alternative means or at alternative locations.
- **Right to a Paper Copy:** Request a paper copy of this Notice at any time, even if you previously agreed to receive it electronically.

COMPLAINTS

If you believe your privacy rights have been violated, you may contact:

Privacy Officer
Dr. Marc Lukosavich, DC
Lukosavich Chiropractic Center, PC
48881 Hayes Road, Shelby Township, MI 48315
Phone: 586-532-6373
Email: lukochiro@gmail.com

You may also contact:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

You will **not** be retaliated against for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of this Notice of Privacy Practices.

Patient Name: ________________________________

Signature: ___________________________________

Date: __________________

If signed by personal representative, describe relationship: __________________________

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

Effective: 02/16/2026

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 ____