

Patient Name: _____

NETWORK HEALING ARTS
Dr. Ellen Levy, D.C., N.D.
404-256-2244

Name: _____ Today's Date: _____
Home Phone: _____ Cell Phone: _____
E-mail Address: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ SS#: _____
Driver's License Number: _____ State: _____ Expiration Date: _____
Sex: M _____ F _____ Height: _____ Weight: _____ Referred By: _____
Marital Status: M S D W Number of Children: Boys _____ Girls _____

Employer: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Work Phone: _____ Years at Job: _____

Name of Spouse: _____ Birth Date: _____ SS#: _____
Spouse's Employer: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Work Phone: _____ Years at Job: _____

Emergency Contact Name _____ Relationship _____
Address _____ Phone _____

Person financially responsible if not patient (if patient is a child, complete employment information for a parent or guardian): _____

Major Complaints: _____

Is this due to an accident? Yes No Type of Accident: Auto Work Home Other

Do you have health insurance? Yes No
Insurance Company _____ Plan/Group # _____
ID #: _____ Address: _____

Major Medical: _____ Address: _____
ID #: _____ Group #: _____
Name of Insured: _____ SS# of Insured: _____

Patient Name: _____

PAYMENT IS DUE AT THE TIME OF SERVICE

I hereby assign all medical and/or surgical benefits to which I am entitled, including Major Medical, Medicare, private insurance, or any other health plans to _____. This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____ Date: _____

Notice: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance. On all insurance the deductible must be met in the beginning unless prior arrangements are made. I (we) agree to pay for services rendered to the above-mentioned patient as the charges are incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Spouse or Guardian's Signature: _____ Date: _____

Family History

Parents living: Father (age) _____ Mother (age) _____

Brothers _____ Sisters _____

Is there any family history of the following?

Diabetes _____ Asthma _____ Cancer _____ Mental Disease _____

Heart Disease _____ Lung Disease _____ Arthritis _____ Allergies _____

Any other (specify) _____

Personal History

Childhood Diseases: Measles _____ Mumps _____ Chicken Pox _____

Unusual Childhood Diseases: _____

Do you smoke? ___ How many? _____ Do you drink coffee? ___ How much? _____

Do you drink alcohol? _____ How much? _____

Do you take any drugs? _____ List names: _____

Do you take any vitamins? _____ List names? _____

Do you exercise? _____ Regularly _____ Infrequently _____ Seldom _____

Are you pregnant now? _____ Last menstrual period: _____

Do you have a pacemaker? _____

Hobbies if any: _____

Patient Name: _____

Past History:

List any significant injuries (slips, falls, auto accidents, etc.) and give dates: _____

Have you had any previous back trouble? Yes No If yes, describe and give dates: _____

List all of your current health problems: _____

List any past significant illness: _____

List all surgeries (give dates): _____

Are you taking any medications now? _____ List Names: _____

List any known allergies: _____

List all abnormalities: _____

Have you seen a chiropractor before? Yes No Date of last adjustment: _____

Name and address of your D.C.: _____

Date of last physical exam: _____ Findings: _____

List any other doctors seen and treatment received: _____

Have you ever been in an automobile accident? _____ When? _____

Have you ever been in a work-related accident or any work-related injury for which you received treatment? _____ When? _____

Have you had x-rays taken during the past two (2) years? Yes No

What part of your body? _____

If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, including whether they occur daily, occasionally, etc.: _____

Would you say you are under a lot of stress? _____ If yes, explain: _____

Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc.? _____

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Women: Do you experience any pain or discomfort before, during, or after your menstrual cycle? Do you experience any pain or discomfort during the cycle week (regardless of whether you menstruate, are in menopause, skip your period periodically, or have had surgical removal of part or all of the reproductive organs)? During the cycle week, are you grouchy? Irritable? Have crying spells? Feel uptight, more nervous, or any other specific problems? _____

Chief complaint: _____

Describe present complaint fully: _____

Duration of present condition: _____

What do you believe caused this condition? _____

If due to auto accident or injury at work, please explain: _____

When were you last seen by a physician? _____

For what purpose? _____

Your doctor's name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone number: _____ Significant diagnosis by your doctor: _____

List all food and beverages taken more than three times per week: _____

TO BE COMPLETED BY DOCTOR

Physical examination

Temperature: _____ Pulse: _____ Respiration: _____

Blood pressure: Sitting _____ Lying _____

General appearance: _____

X-rays: _____ Findings: _____

Lab work: _____

Diagnosis: _____

Treatment plan: _____

Patient Name: _____

MUSCULOSKELETAL SYSTEM					
HEAD		SHOULDERS		HIPS, LEGS, AND FEET	
	Frequent headache		Pain in shoulders R/L		Pain in buttock
	Head feels heavy		Pain across shoulders		Pain down leg R/L
	Light-headedness		Muscle spasms		Knee pain R/L
	Loss of smell		Can't raise arm		Leg cramps
	Loss of taste		Above shoulder level		Pins & needles
	Loss of balance		Over head		Numbness in toes
	Dizziness				Cold feet
					Swollen ankles
					Swollen feet
NECK		ARMS & HANDS		OTHER (please describe)	
	Pain in neck		Pain in upper arm		
	Neck pain with movement		Pain in forearm		
	Swelling in neck		Pain in hands		
	Stiff neck		Pain in fingers		
	Pinched nerve in neck		Pins & needles		
	Muscle spasms		In arms		
	Grinding sounds		In fingers		
	Popping sounds		Fingers go to sleep		
			Hands cold		
MID BACK		Swollen joints in fingers		LOW BACK	
	Mid back pain		Sore joints in fingers		Low back pain
	Pain between shoulder blades		Loss of grip strength		Muscle spasms in low back
	Pain from front to back				
	Pain over kidney area				
	Muscle spasms in mid back				