Harvey J. Markovitz, D.C.

Name: _____ Date: _____

Email Address: _____ (_____)_____
HOME PHONE

Address: _____ (_____)_____
WORK PHONE

City: _____ CA Driver's License #: _____

State: _____ Zip: _____ Sex: M / F Age: _____ Birthdate: ____ /____ /____

Employer: _____ Referred By: _____

Primary Care Physician: _____

Check If You Are: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Who is responsible for your bill:

❑ Self

❑ Spouse → Name:_____ Birthdate:___ /___/___Social Security #: _____

❑ Employer → Employer Address:_____

Your Occupation:_____ Employer Phone: _____

❑ Insurance → **We will need to make a copy of your insurance card at the front desk.**
*Also **IF YOU ARE NOT THE INSURED** Plan Member*
Please Complete: Name of Insured Person: _____
Social Security or Insurance ID #: _____
Insured Person's Date of Birth: _____ /_____/_____

❑ Other → _____

Payment will be made by:

❑ Cash
❑ Check
❑ VISA/Master Card
❑ Health Insurance
❑ Auto Insurance
❑ Worker's Compensation

If Married:
Spouse's Name: _____ Spouse's Employer: _____ Work Phone: (____)_____

If Child:
Parent's Name: _____ Parent's Employer: _____ Work Phone: (____)_____

In case of emergency call: _____ Phone: (___)_____ Relationship: _____

Number & ages of children: _____

Please Check The Type Of Care Desired: ❑ Temporary Pain Relief ❑ Lasting Correction

PRESENT COMPLAINTS
PLEASE CHECK ALL ANSWERS AND FILL IN BLANKS WHERE APPROPRIATE.

In the space below, please describe the present complaint(s) which brought you to this clinic for care. After completing this first section, please complete ALL of the following pages. The information you provide concerning past and present symptoms and diseases assists the Doctor in early understanding of your state of health. Thank you.

1. Primary Complaint: _____ 2. Secondary Complaint: _____

_____ _____

_____ _____

_____ _____

2. Pain Rating Scale

Instructions: Please make an "x" on the lines to indicate the pain level of your ***primary*** and ***secondary*** complaint.

i. What is your pain RIGHT NOW?

	0	1	2	3	4	5	6	7	8	9	10
Primary pain:											
Secondary pain:											

no pain *unbearable pain*

ii. What is your typical AVERAGE pain?

	0	1	2	3	4	5	6	7	8	9	10
Primary pain:											
Secondary pain:											

no pain *unbearable pain*

iii. What is your pain AT ITS WORST?

	0	1	2	3	4	5	6	7	8	9	10
Primary pain:											
Secondary pain:											

no pain *unbearable pain*

RE: Primary Complaint

3. How often are the complaints present:
   - ❑ Constant (100%)
   - ❑ Frequent (75%)
   - ❑ Intermittent (50%)
   - ❑ Occasional (25%)

4. Since your problem began is the pain:
   ❑ Increasing ❑ Decreasing ❑ Not Changing

5. When did your problem begin?
   (Specific date if possible): _____

6. Did your problem begin:
   - ❑ Immediately after a specific incident
   - ❑ Multiple Incidents
   - ❑ Gradually develop over time

7. Describe how your problem began: _____

8. Have you lost any days of work? ❑ Yes ❑ No
   Dates: _____

RE: Secondary Complaint

3a. How often are the complaints present:
   - ❑ Constant (100%)
   - ❑ Frequent (75%)
   - ❑ Intermittent (50%)
   - ❑ Occasional (25%)

4a. Since your problem began is the pain:
   ❑ Increasing ❑ Decreasing ❑ Not Changing

5a. When did your problem begin?
   (Specific date if possible): _____

6a. Did your problem begin:
   - ❑ Immediately after a specific incident
   - ❑ Multiple Incidents
   - ❑ Gradually develop over time

7a. Describe how your problem began: _____

8a. Have you lost any days of work? ❑ Yes ❑ No
   Dates: _____

RE: Primary Complaint

9. What treatment have you received for this present condition:

- ❑ Chiropractic
- ❑ Medication
- ❑ Surgery
- ❑ Spinal injections
- ❑ Therapy from PT
- ❑ A back support
- ❑ Other _____

10. Were you treated previously for a different occurrence of this same condition?

- ❑ No
- ❑ Chiropractor
- ❑ MD
- ❑ Therapist
- ❑ Other

Specify dates & type of treatment with results: _____

_____

_____

11. What makes your problem **better**:

❑ Nothing ❑ Lying Down ❑ Walking
❑ Standing ❑ Sitting ❑ Inactivity
❑ Movement/Exercise
❑ Other: _____

12. What makes your problem **worse**:

❑ Nothing ❑ Lying Down ❑ Walking
❑ Standing ❑ Sitting ❑ Inactivity
❑ Movement/Exercise
❑ Other: _____

RE: Secondary Complaint

9a. What treatment have you received for this present condition:

- ❑ Chiropractic
- ❑ Medication
- ❑ Surgery
- ❑ Spinal injections
- ❑ Therapy from PT
- ❑ A back support
- ❑ Other _____

10a. Were you treated previously for a different occurrence of this same condition?

- ❑ No
- ❑ Chiropractor
- ❑ MD
- ❑ Therapist
- ❑ Other

Specify dates & type of treatment with results: _____

_____

_____

11a. What makes your problem **better**:

❑ Nothing ❑ Lying Down ❑ Walking
❑ Standing ❑ Sitting ❑ Inactivity
❑ Movement/Exercise
❑ Other: _____

12a. What makes your problem **worse**:

❑ Nothing ❑ Lying Down ❑ Walking
❑ Standing ❑ Sitting ❑ Inactivity
❑ Movement/Exercise
❑ Other: _____

13. How would you grade your general stress level: ❑ None ❑ Minimal ❑ Moderate ❑ Great

14. Physical activity at work:

❑ Sedentary 50% or more ❑ Manual Labor ❑ Light Manual Labor ❑ Heavy Manual Labor

15. General Physical activity: ❑ No regular exercise

Exercise type(s): _____

Frequency of exercise: _____ Time each work-out: _____

16. Are your complaints affecting your ability to work or otherwise be active?

❑ No effect ❑ Some physical restrictions *(able to perform tight duty work & household tasks)*
❑ Need limited assistance ❑ Need assistance often
❑ Significant inability to function without assistance
❑ Am totally disabled (impaired) Cannot care for self.

17. List any relatives that have or have had a similar problem:_____

_____

18. Have you been treated for any health condition by a physician in the last year: ❑ No

If ”Yes” explain:_____

19. Have you or any relative received Chiropractic treatment previously? ❑ No

If ”Yes” explain:_____

20. List the approximate dates of any operations, unusual diseases, serious illnesses, broken bones or accidents you have had:

_____

_____

21. List all drugs or medications that you have used recently including aspirin, sleeping pills, birth control, etc:

_____

_____

22. PLEASE CHECK ANY OF THE FOLLOWING DISEASES YOU MAY CURRENTLY HAVE OR HAVE HAD:

❑ Appendicitis	❑ Depression	❑ Mental Disorder
❑ Tuberculosis	❑ Ulcer	❑ Pollo
❑ Cancer	❑ Prostate Problems	❑ Emphysema
❑ Pneumonia	❑ Chicken Pox	❑ Asthma
❑ Mumps	❑ Venereal Infection	❑ HIV
❑ Pleurisy	❑ Typhoid Fever	❑ Scarlet Fever
❑ Stroke	❑ Goiter	❑ Whooping Cough
❑ Hepatitis C	❑ Lumbago	❑ Anorexia
❑ Malaria	❑ Aortic Aneurysm	❑ Rheumatic Fever
❑ Diabetes	❑ Kidney Stones/Disorders	❑ Small Pox
❑ Arthritis	❑ Alcoholism	❑ Angina
❑ Measles	❑ Diphtheria	❑ Bladder Infection
❑ Influenza	❑ Anemia	❑ Other: _____

23. PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU PAST OR PRESENT:

❑ Tobacco use/ amount: _____ ❑ Alcohol use/ amount: _____ ❑ Drug or alcohol dependency

❑ Coffee/tea/cola/chocolate/ amount: _____ ❑ Dairy products: _____

24. PLEASE **UNDERLINE** IF THIS IS A CURRENT COMPLAINT.
PLEASE **CHECK** IF YOU HAVE HAD THIS SYMPTOM IN THE **PAST 5 YEARS**.

GENERAL SYMPTOMS

- ❑ Low back pain
- ❑ Headache
- ❑ Neck pain
- ❑ Shoulder pain
- ❑ Pain in upper arm or elbow
- ❑ Hand pain
- ❑ Upper back pain
- ❑ Pain in upper leg or hip
- ❑ Pain in lower leg or hip
- ❑ Pain in ankle of foot
- ❑ Jaw pain
- ❑ Fever chills
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Excessive weight loss
- ❑ Excessive weight gain
- ❑ Loss of appetite
- ❑ Numbness in arms/hands
- ❑ Numbness in legs/feet
- ❑ Allergies
- ❑ Neuralgia

RESPIRATORY

- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Chest pain
- ❑ Difficult breathing

SKIN

- ❑ Skin eruptions
- ❑ Itching
- ❑ Bruises easily
- ❑ Dryness
- ❑ Boils
- ❑ Varicose veins
- ❑ Sensitive skin
- ❑ Hives or allergy
- ❑ Rash
- ❑ Dermatitis/eczema

EYES, EARS, NOSE & THROAT

- ❑ Falling vision
- ❑ Nearsighted
- ❑ Crossed eyes
- ❑ Eye pain
- ❑ Deafness
- ❑ Earache
- ❑ Ear discharge
- ❑ Nose bleeds
- ❑ Nasal obstruction
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Hay fever
- ❑ Asthma
- ❑ Dental decay
- ❑ Gum trouble
- ❑ Frequent colds
- ❑ Enlarged thyroid
- ❑ Tonsillitis
- ❑ Sinus infection
- ❑ Nasal drainage
- ❑ Enlarged glands

CARDIO-VASCULAR

- ❑ Rapid heart
- ❑ Slow heart
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Heart stroke
- ❑ Hardened arteries
- ❑ Swelling ankles
- ❑ Poor circulation
- ❑ Paralytic stroke

GENITOURINARY

- ❑ Frequent urination
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Pus in urine
- ❑ Kidney infection
- ❑ Bed wetting

FEMALE

- ❑ Painful menstrual periods
- ❑ PMS
- ❑ Excessive flow
- ❑ Cramps/backache
- ❑ Hot flashes
- ❑ Irregular cycles
- ❑ Miscarriage
- ❑ Vaginal discharge
- ❑ Congested breast
- ❑ Lumps in breast
- ❑ Menopausal syndrome

MUSCLE & JOINT

- ❑ Stiff neck
- ❑ Back ache
- ❑ Swollen joints
- ❑ Tremors
- ❑ Painful tailbone
- ❑ Foot trouble
- ❑ Pain between shoulders
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture

GASTROINTESTINAL

- ❑ Excessive hunger
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Pain over stomach
- ❑ Difficulty swallowing
- ❑ Distended abdomen
- ❑ Constipation
- ❑ Diarrhea
- ❑ Colon trouble
- ❑ Hemorrhoids/piles
- ❑ Intestinal worms/parasites
- ❑ Live trouble
- ❑ Gall bladder trouble
- ❑ Jaundice
- ❑ Colitis
- ❑ Loss of bladder control
- ❑ Heartburn/indigestion

PREGNANT

- ❑ Last menstrual period: _____

❑ Other:_____

25. Do you have a permanent disability rating: ❑ No ❑ Yes If "Yes" location: _____

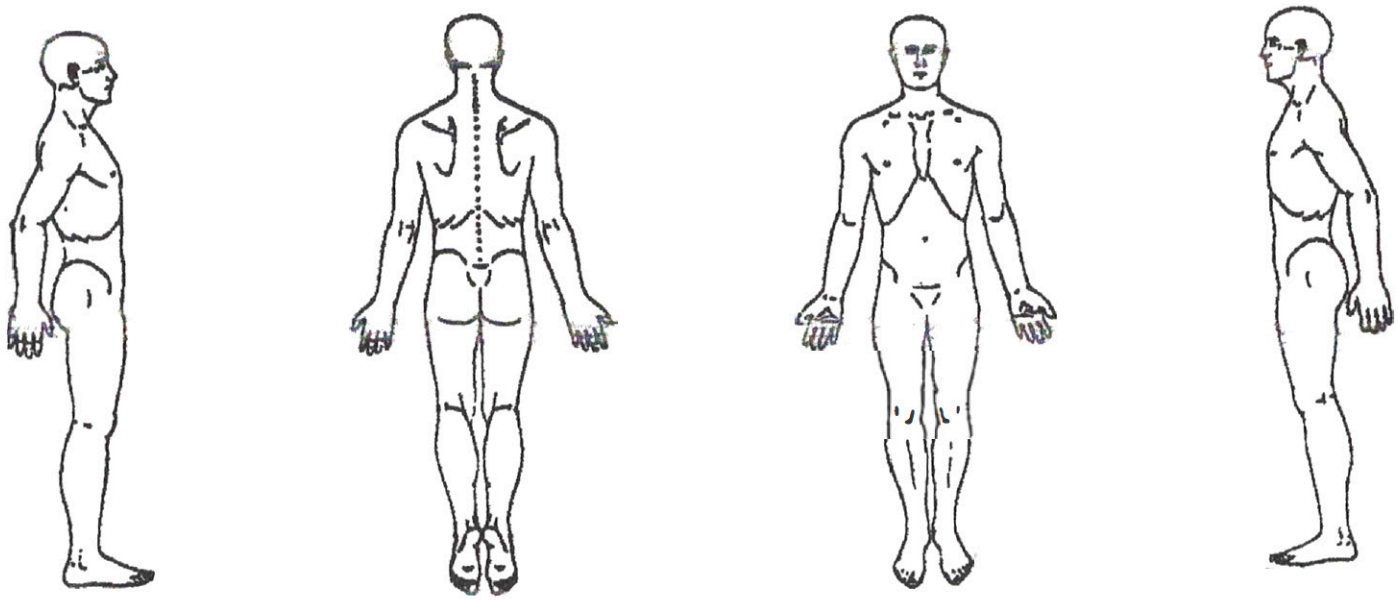
Date received: _____ /_____/ _____ Rating Percentage: _____ %

26. MARK the areas on your body where you feel the described sensations.

USE appropriate symbols(s).
MARK areas of radiation.
INCLUDE all affected areas.

ACHING	BURNING	CRAMPING	TINGLING	SHARP
XXXXXX	//////	ZZZZZZ	======	######
XXXXXX	//////	ZZZZZZ	======	######

STABBING	NUMBNESS	DULL	THROBBING	SHOOTING
OOOOOO	++++++	??????	TTTTTT	SSSSSS
OOOOOO	++++++	??????	TTTTTT	SSSSSS



Release and Assignment

Our office composed the following financial policy to clarify our billing charges and procedures in the hope of avoiding any misunderstandings or unnecessary upsets in the future regarding unanticipated charges. Please read it and sign at the bottom. If you need any clarification please speak to the office manager.

I _____ , understand that although I have assigned insurance benefits to this office, it is probable that my insurance coverage will be less than the amount billed. Unless my doctor has a contractual agreement with my insurance company that states otherwise, I acknowledge that I am responsible for any charges refused or discounted by my insurance company and that it is my responsibility to pay any remaining balance of my bill once the insurance benefits have been received. Except as to the above, I understand that this office does not bill the patient but, rather, expects payment of my estimated portion on the day treatment is rendered.

Further, I agree to pay for any collections or legal charges incurred in the collection of these uncovered charges should I fail to pay them in a prompt manner. Any balance over three months past due will be assessed an additional 1.5% monthly fee. I also understand that a $45 missed appointment fee will be charged for any missed appointment, but that this fee will not apply if proper 24-hour notice is given.

Signature:_____Date:_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you get access to this information. Please review it carefully.

Dr. Markovitz is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Information

- **Treatment:** We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Dr. Markovitz. It is our policy to provide a substitute health care provider, authorized by Dr. Markovitz, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.
- **Payment:** We may disclose your health information to your insurance provider for the purpose of payment or health care operations. As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to. Dr. Markovitz for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.
- **Workers Comp:** We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
- **Emergencies:** We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food & Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health Information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons: We may disclose your health information to coroners or medical examiners.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies: We may disclose your health information for military, national security, prisoner, and government benefits purposes.

Reminders: We may contact you to remind you of an appointment in the office or for a missed appointment. As a courtesy to our patients, it is a policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not home, we will leave a reminder message on the answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment.

Change of Ownership: In the event that Dr. Markovitz is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that Dr. Markovitz is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery.
- You have the right to inspect and copy your health information.
- You have the right to request that Dr. Markovitz amend your protected health information. Please be advised that Dr. Markovitz is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reasons and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health Information.
- You have a right to a paper copy of this notice of Privacy Practices at any time upon request.

Changes to This Notice of Privacy Practices: Dr. Markovitz reserves the right to amend this notice of Privacy Practices at any time in the future, and will make the new provisions effective for an information that it maintains. Until such amendment is made, Dr. Markovitz is required by law to comply with this notice.

Complaints: Complaints about your privacy rights, or how Dr. Markovitz has handled your health information, should be directed to the Business Administrator at (831)476-6906. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

200 Independence Avenue SW

Room 509F HHH Building

Washington, DC 20201

This notice is effective as of April 14, 2003.

I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide Dr. Markovitz with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described above.

_____	_____	_____
Print Patient Name	Date	Patient Signature