

Dr Neil Levin

Chiropractor, Nutritionist, Fitness Trainer

Please fill out the following form in as much detail as possible.

Date _____

Name _____

Address _____

Home Phone _____ Office Phone _____

Cell Phone _____ E-mail address _____

Age _____ Date of Birth _____ Occupation _____ Sex (M) _ (F) _

Social Security Number _____ Height _____ Weight _____ Referred by _____

Employer _____ Address _____

Married ___ S ___ W ___ D ___ # of Children _____ Spouses Name _____

Insurance Info: ___ Major Medical ___ BC/BS ___ Auto ___ Workers Comp ___ Medicare ___ Other

If you are not the primary insurance holder, please provide your spouse's Social Security number and date of birth: SS#: _____ DOB: _____

How many servings of Fruits and Vegetables do you eat on an average day? _____

How many times per week do you eat fish (not fish sticks)? _____

What types of fish do you usually eat? _____

Do you have a bowel movement at least once a day? (If not, describe) _____

Do you take vitamins? Yes ___ No ___ If yes, please list them _____

Do you exercise regularly? Yes ___ No ___ What type of exercise and how often? _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes ___ No ___ Describe _____

Major complaints and symptoms - please be as specific as you can - Describe how and when the problem began. _____

Have you lost any time from work? _____ Day and date you last worked _____

Have you ever had this condition before or a similar condition? _____

When? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you been treated by a Medical Physician for this ailment? ___ If so what type? _____

Diagnosis of previous physician: _____

Length of time under care _____ Results _____

Family physician's name _____

Please send a report to my family physician. Yes ___ No ___ Address: _____

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)? _____ When? _____

Are you allergic to anything you are aware of? _____

Are you presently taking any medication (aspirin included)? Yes ___ No ___

If yes, name them here: _____

Have you ever broken any bones? (fractures) _____ Any dislocations? _____

Please list any operations you have had, along with the dates: _____

Do you have any health problems not listed above? _____

Do you faint easily? _____

Habits: (please check) Cigarettes ___ Quantity _____ Coffee ___ Quantity _____
Alcohol ___ Quantity _____ Tea ___ Quantity _____

Hobbies: _____

Have you been treated for any health condition by a physician in the past year? _____

If Yes, what condition? _____

Have you lost or gained weight in the past year? _____

Female: Date of last menstrual period _____

Do you have any reason to believe that you may be pregnant? Yes ___ No ___

Use this space for any additional information you may wish to discuss _____

Have you had or do you now have any of the following symptoms or diseases which are or have been a significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 6 months) or **P** if you ever had this condition in the past.

- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Lights Bother Eyes |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Ears Ring/ Buzz |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Face Flushed |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Frequent loss of balance |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Pins/needles in Arms | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Cold feet/hands |
| <input type="checkbox"/> Weakness in arms | <input type="checkbox"/> Venereal disease/HIV/AIDS |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Flat feet | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Pins/needles in Legs | <input type="checkbox"/> Frequent Fever |
| <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Weakness in legs | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Leg Cramps |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Gall Bladder Problems |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Blood in stool or urine |
| <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Belching/indigestion |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Menstrual Difficulties |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Alcohol/Drug abuse |
| <input type="checkbox"/> Heart Attack/Stroke/Mini-stroke | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Depression | |

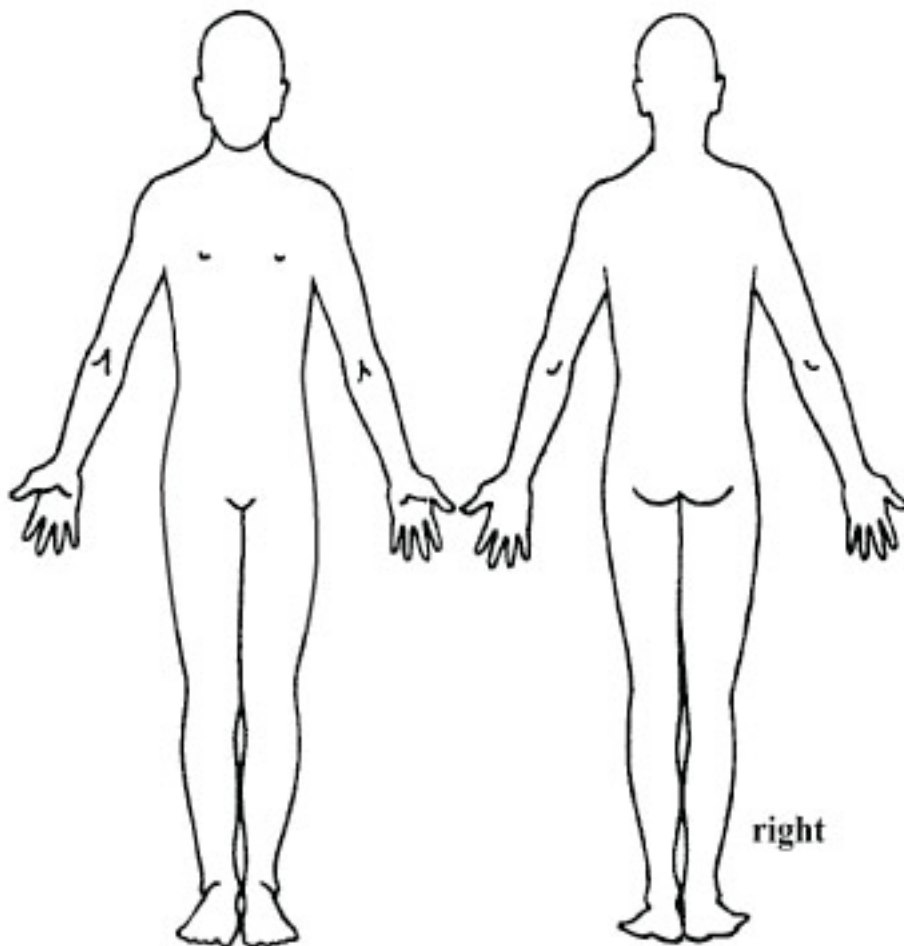
Family History:

Did your father or mother have any of the following: Use M for mother and F for father or B for both.

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcer or digestive problems |
| <input type="checkbox"/> Arthritis-Rheumatism | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Neurological issues (i.e.: MS, peripheral neuropathy, ALS, restless leg syndrome, etc...) | |

Show areas of pain or unusual sensation

Color in areas of pain and note the pain level on a scale of 1 (the mildest pain) to 10 (the most extreme pain). In areas of unusual sensation use xxx's and note the type of sensation you feel (i.e.: burning, pin & needles, numbness etc...). Rate the sensation on a scale of 1-10 as well.



- _ We invite you to discuss any questions regarding our services. The best health services are based on a friendly mutual understanding between provider and patient.
- _ I acknowledge that any dietary supplement suggestions made by Dr. Levin are entirely nutritional in nature, and are not intended to diagnose, treat or cure any disease or condition.
- _ My medical doctor is my primary care physician and I am responsible for discussing any diseases, dietary changes or nutrient changes with him/her.
- _ Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made. I understand and agree that insurance policies are an agreement between the insurance carrier and myself and that all services rendered to me are charged directly to me. I am personally responsible for payment and will be responsible for any expenses incurred in collecting my account.
- _ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- _ I understand the above information and guarantee this form was completed correctly to the best of my Knowledge. I understand that it is my responsibility to inform this office of any changes in my medical or insurance status.

PATIENT SIGNATURE _____ DATE _____