

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M / F  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ Patient Primary Language \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Health Plan: \_\_\_\_\_  
Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_ Spouse Name \_\_\_\_\_  
Spouse Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Primary Care Physician Name \_\_\_\_\_ PCP Phone \_\_\_\_\_

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

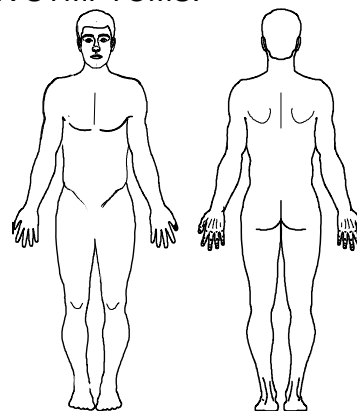
**DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:**

- Headache    Neck Pain    Mid-back Pain    Low Back Pain  
 Other \_\_\_\_\_

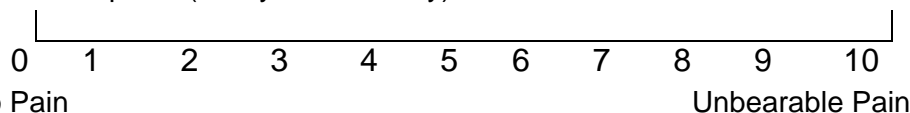
Is this?    Work Related    Auto Related    N/A

Date Problem Began: \_\_\_\_\_

How Problem Began: \_\_\_\_\_



Current complaint (how you feel today):



How often are your symptoms present?

- (Intermittent)    0 – 25%    26 – 50%    51 – 75%    76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

**HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?**    No    Yes

Date(s) taken: \_\_\_\_\_ What areas were taken? \_\_\_\_\_

Please check all of the following that apply to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Recent Fever   | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Menstrual Problems  |
| <input type="checkbox"/> High Blood Pressure                                    | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> Stroke (date) _____                                    | <input type="checkbox"/> Currently Pregnant, # weeks _____   |
| <input type="checkbox"/> Corticosteroid Use (cortisone, prednisone, etc.) _____ | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Taking Birth Control Pills                             | <input type="checkbox"/> Marked Morning Pain/Stiffness   |
| <input type="checkbox"/> Dizziness/Fainting                                     | <input type="checkbox"/> Pain Unrelieved by Position or Rest   |
| <input type="checkbox"/> Numbness in Groin/Buttocks                             | <input type="checkbox"/> Pain at Night   |
| <input type="checkbox"/> Cancer/Tumor (explain) _____                           | <input type="checkbox"/> Visual Disturbances   |
| _____   | <input type="checkbox"/> Surgeries _____   |
| <input type="checkbox"/> Osteoporosis   | _____  |
| <input type="checkbox"/> Epilepsy/Seizures                                      | _____  |
| <input type="checkbox"/> Other Health Problems (explain) _____                  | <input type="checkbox"/> Medications _____   |
| _____   | _____  |
| _____   | _____  |

**Family History:**    Cancer    Diabetes    High Blood Pressure  
 Heart Problems/Stroke    Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**INFORMED CONSENT TO  
CHIROPRACTIC ADJUSTMENTS AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks that have been associated with treatment, including, but not limited to, fractures, disc injuries, strokes, TIAs, cardiac arrest, dislocations and sprains. It should be noted that the more severe risks are extremely remote. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand and am informed that possible alternatives to chiropractic treatment include, but are not necessarily limited to rest, physical therapy, acupuncture, massage, over the counter medication, and osteopathic/medical care involving prescription drugs and/or surgery.

I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient

Signature of patient's representative, if necessary, (e.g., if patient is a minor or physically/legally incapacitated)

\_\_\_\_\_

\_\_\_\_\_

Print Patient's Name

Print Name of Patient's Representative

\_\_\_\_\_

\_\_\_\_\_

Date Signed \_\_\_\_\_

Date Signed \_\_\_\_\_

Translated by (if applicable)

\_\_\_\_\_

Date Signed \_\_\_\_\_

*--- Below is for Office Use Only ---*

This form was verbally explained to the patient or to his/her representative by \_\_\_\_\_

on \_\_\_\_\_. Initial here as evidence of having personally performed this duty: \_\_\_\_\_

*For the practice of Gary N. Lewkovich, DC and Jason Edwards, DC*

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS**

I, \_\_\_\_\_, acknowledge and agree to the following:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; or b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order obtain payment for my treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the above information, and will accept full responsibility for asking any questions I may have.**

\_\_\_\_\_  
**Printed Name of Individual**

\_\_\_\_\_  
**Signature of Individual**

\_\_\_\_\_  
**Signature of Legal Representative  
(e.g., Guardian, Parent, if a minor)**

\_\_\_\_\_  
**Relationship**

**Date Signed** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Understanding the Importance of the Form Below**

If you have a work-related injury in California, your employer can determine who you see for treatment for at least the first 30 days. If you chose to see your own medical or chiropractic doctor, you would have to pay for these services yourself. Most people do not like this arrangement but do not learn of this restriction until it is too late to change it.

Fortunately, Workers' Compensation law allows the employee the opportunity to avoid this problem by pre-designating a doctor **prior** to a work injury. If you pre-authorize, in writing, a specific doctor (chiropractic or medical) to treat you if you are injured on the job, you will be able to see that doctor without delay. Additionally, you will have the opportunity to continue with reasonable care as long as you need it. You are further protected by the right to change your mind and designate a different doctor at a later time, prior to a given work injury.

If you elect to exercise this right protecting your freedom of choice in healthcare, please complete and sign the form below. Thank you for your assistance.

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**EMPLOYEE'S DESIGNATION OF PERSONAL CHIROPRACTOR  
(California Labor Code Section 4601)**

Attention: Personnel

To: \_\_\_\_\_  
Employer

From: \_\_\_\_\_ Employee#: \_\_\_\_\_  
Employee

This letter serves as notification that if, during the course of my employment I experience an industrial injury of a musculo-skeletal nature, I hereby request to be treated by my personal chiropractor.

I hereby designate Jason A. Edwards, DC as my "personal chiropractor" pursuant to Section 4601 of the California Labor Code.

Dr. Jason Edwards is my regular chiropractor who has previously directed my treatment and who retains my chiropractic treatment records, including my chiropractic history.

Signed By: \_\_\_\_\_ Date: \_\_\_\_\_

Received By: \_\_\_\_\_ Date: \_\_\_\_\_