



# A-CARE CHIROPRACTIC & ACUPUNCTURE

## Dr. Alexander Leybovich, D.C.

870 North Coit Road, Suite 2651 \* Richardson, TX 75080

### Confidential Client Information

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

SS#: \_\_\_\_\_ Driver's License / I.D.#: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Please indicate if your visit is a result of the following:

Auto Accident  Workers' Compensation  Other

How did you hear about us?

Internet Search  A-Care Website  Yellow Pages  
 Friend/Family: \_\_\_\_\_  Other: \_\_\_\_\_

What health concerns would you like to discuss with Dr. Alex today?

List any major concerns in order of importance to you:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



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**Insurance Information**

Insurance Company: \_\_\_\_\_ Provider Services Phone #: \_\_\_\_\_

Group #: \_\_\_\_\_ Member I.D. #: \_\_\_\_\_ HMO / PPO / Medicare (*circle one*)

**FOR OFFICE USE ONLY**

Individual Deductible: \_\_\_\_\_ Amount Met: \_\_\_\_\_ Out of Pocket: \_\_\_\_\_

Family Deductible: \_\_\_\_\_ Amount Met: \_\_\_\_\_ Out of Pocket: \_\_\_\_\_

Chiro Coverage %: \_\_\_\_\_ Co-Pay: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Visit Maximum: \_\_\_\_\_ /per \_\_\_\_\_

Limitations on Chiropractic Care: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## Health History

Please use the following rating system as a guideline when answering the questions below:

0% - 24% of the time	Intermittently
25% - 49% of the time	Frequently
50% - 75% of the time	Occasionally
76% - 100% of the time	Constantly

**How often do you experience your symptoms?**

Intermittently     Frequently     Occasionally     Constantly

**How often have your symptoms interfered with work?**

Intermittently     Frequently     Occasionally     Constantly

**How often have your symptoms interfered with your social activities?**

Intermittently     Frequently     Occasionally     Constantly

**How much have your symptoms interfered with your work?**

Intermittently     Frequently     Occasionally     Constantly

**Please indicate the frequency of the following activities at work:**

Sitting:             Intermittently     Frequently     Occasionally     Constantly

Standing:            Intermittently     Frequently     Occasionally     Constantly

Computer Work:     Intermittently     Frequently     Occasionally     Constantly

On the Phone:        Intermittently     Frequently     Occasionally     Constantly

**How would you rate your symptoms on a scale of 1 – 10? (Rating of 10 = most severe)** \_\_\_\_\_

**When did you first experience your symptoms?** \_\_\_\_\_

**How do you think your symptoms originated?** \_\_\_\_\_

**Describe any activities that aggravate or trigger your symptoms:** \_\_\_\_\_

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### Health History

**How have your symptoms changed over time?**

- Getting Better       Staying About the Same       Getting Worse

**Who else have you consulted regarding your current symptoms?**

- Chiropractor       E.R. Physician       Primary Care Physician / M.D.  
 Neurologist       Orthopedist       Massage Therapist  
 Physical Therapist       No One       Other: \_\_\_\_\_

**How would you rate your overall health?**

- Excellent       Good       Fair       Poor

**What type of exercise do you do?**

- Strenuous       Moderate       Light       None

**Do you currently smoke or use tobacco products?**

- Yes       No

Tobacco Use Frequency: \_\_\_\_\_ daily / weekly / monthly (*Circle one*)

**Medical Conditions** – Please list any conditions, hospitalizations, surgeries and/or traumas that you have or have had in addition to the year of each event.

Year	Condition/Surgery



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**Medications** – Please list all current prescription medications, herbal remedies, nutritional supplements and over-the counter medications.

Medication Name	Purpose	Dose	How Often	Date Started

**Allergies** – Please list medications, seasonal, environmental, food allergens.

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**Infectious Disease** – Please list and describe any exposure you have or have had with an infectious disease.  
(i.e. – hepatitis, tuberculosis, AIDS/HIV)

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**Conditions** – Please circle either Past or Present if you have experienced or are experiencing any of the conditions below.

Headaches	Past / Present	Cancer	Past / Present
High Blood Pressure	Past / Present	Tumor	Past / Present
Heart Attack	Past / Present	Asthma	Past / Present
Chest Discomforts	Past / Present	Chronic Sinusitis	Past / Present
Stroke	Past / Present	Hepatitis	Past / Present
Angina	Past / Present	Diabetes	Past / Present
Kidney Stones	Past / Present	Systemic Lupus	Past / Present
Kidney Disorders	Past / Present	Epilepsy	Past / Present
Bladder Infection	Past / Present	ALS	Past / Present
Discomfortful Urination	Past / Present	Drug/Alcohol Dependence	Past / Present
Frequent Urination	Past / Present	Dermatitis/Eczema	Past / Present
Loss of Bladder Control	Past / Present	Excessive Thirst	Past / Present
Prostate Problems	Past / Present	General Fatigue	Past / Present
Abnormal Weight Gain	Past / Present	Muscular Incoordination	Past / Present
Abnormal Weight Loss	Past / Present	Dizziness	Past / Present
Loss of Appetite	Past / Present		
Ulcer(s)	Past / Present	<b>FEMALES ONLY</b>	
Liver/Gall Bladder Disorder	Past / Present	Pregnancy	Past / Present
Arthritis	Past / Present	Birth Control	Past / Present
Rheumatoid Arthritis	Past / Present	Hormonal Replacement	Past / Present



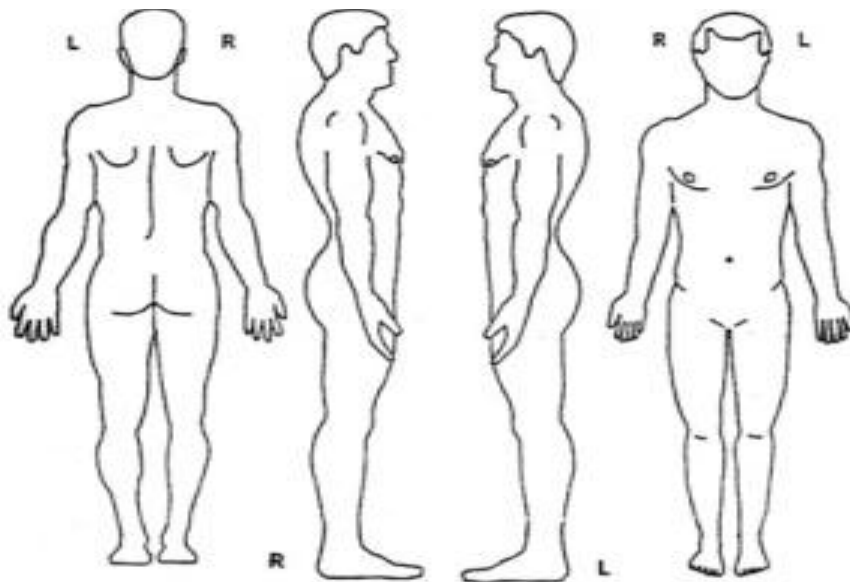
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## Health History Questionnaire for Chiropractic Care

Indicate on the drawings below where you're experiencing discomfort/symptoms.



**Conditions** – Please circle either Past or Present if you have experienced or are experiencing any of the conditions below.

- |                |                         |                |                               |
|----------------|-------------------------|----------------|-------------------------------|
| Past / Present | Neck Area               | Past / Present | Hip(s)                        |
| Past / Present | Upper Back Area         | Past / Present | Upper Leg(s)                  |
| Past / Present | Mid-Back Area           | Past / Present | Knee(s)                       |
| Past / Present | Lower Back Area         | Past / Present | Ankle(s)                      |
| Past / Present | Shoulder Area           | Past / Present | Foot/Feet                     |
| Past / Present | Elbow/Upper Arm Area(s) | Past / Present | Jaw                           |
| Past / Present | Wrist(s)                | Past / Present | Joint(s) ( <i>stiffness</i> ) |
| Past / Present | Hand(s)                 |                |                               |

### How would you describe your Discomfort?

- |                                       |                                   |  |  |
|---------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Sharp        | <input type="checkbox"/> Numb     | <input type="checkbox"/> Sharp With Motion | <input type="checkbox"/> Shooting with Motion      |
| <input type="checkbox"/> Burning      | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stiff             | <input type="checkbox"/> Stabbing with Motion      |
| <input type="checkbox"/> Dull         | <input type="checkbox"/> Tingly   | <input type="checkbox"/> Achy              | <input type="checkbox"/> Electric-like with Motion |
| <input type="checkbox"/> Other: _____ |                                   |  |  |



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### **Informed Consent for Acupuncture Treatment and Care**

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Dr. Alexander Leybovich, a licensed chiropractor and acupuncturist. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the treatment. I will notify the acupuncturist who is caring for me if I am or become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist things at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

#### **CONCLUSION**

I acknowledge and agree no warranties or representations have been made to me regarding the results I will achieve from this program. I understand results are individual and may vary. I acknowledge I have thoroughly read this waiver and release and fully understand it is a waiver release of liability. By signing this document, I am waiving any right I, or my heirs and/or assigns, may have to bring any and all legal actions or assert any and all claims against Dr. Alexander Leybovich. I represent and warrant I am signing this agreement freely and willfully and not under fraud or duress.

#### **I have read and understand this document.**

Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

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