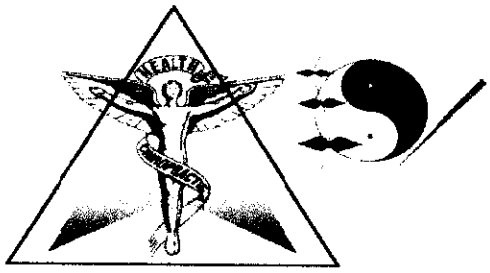
Office of Jaime Lubelczyk DC, LAc
www.531Health.com



Personal Information

Date _____

Patient:_____

Address: _____

_____

(City State Zip)

Best Phone Number to reach you at:

cell/home _____

Alt Phone, cell/home_____

Email address: _____

Sex: __M __F Age____ Date of Birth:_____

Occupation_____

Employer_____

Emergency Notification Info:
Name and relation to you: _____

Phone Number to reach them at: _____

Whom may we thank for referring you?

_____

Everyone

If you would like a receipt to submit to your insurance carrier for reimbursement, or for taxes please ask for it and I will be happy to provide it for you.

Your **Social Security Number** is not being asked for on this form. This is intended as a protection against identity theft. If at some future date it is needed, I will ask for it.

Cancellation Policy

I ask that you give 24 hours notice if you need to cancel an appointment. If this becomes a repeated problem, I reserve the right to charge a fee for appointments not canceled 24 hours in advance. Hopefully this will never be an issue.

Is your condition due to an accident? __Yes __No
Date of accident_____
Type of accident: Home Work Auto Other_____

To whom have you made a report of your accident?
Attorney Auto Insurance

Attorney Name (if applicable)_____

If you are using insurance; what is your relationship to the insured? _____

Financial Agreement

I understand that all services can be paid for with cash, personal check, or credit card. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY BEFORE SIGNING

What your Record Contains:

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. Each time you are here, a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care and treatment. We need this record to provide you with quality care. This notice will tell you about the ways we may use and share medical information about you. It will also describe your rights, and our responsibility to maintain the privacy of your health information.

Use and Disclosure of your Medical Information:

We may use your protected medical information for treatment. We may disclose information to your primary doctor, your referring doctor, and other healthcare providers involved in your treatment, directly or indirectly.
We may use your protected medical information for payment. We may disclose your information to obtain reimbursement for services from your insurance companies. We may disclose your information to your insurance company to obtain precertification for a procedure.
We may use your protected medical information for healthcare operations and research purposes, such as quality assessment and improvement activities, for evaluating employee performance or training programs- without individually identifiable information (your name, SSN, birth date, etc. will be removed).
Certain disclosures may be made without your written authorization. Such disclosures are: communication with family member or other person involved in your care, notification of family member or other person responsible for your care, for public health and safety, in legal proceedings, for law enforcement – whenever we are required by law to disclose personal health information.
Any other uses and disclosures will be made only with your written authorization. You may revoke an authorization at any time in writing. Parents are the representatives of unemancipated minors.

Your Individual Rights:

Although your health records are the physical property of your healthcare provider, you have rights, which you can exercise by presenting a written request to our office.
You have the right to request restrictions on certain uses and disclosures of protected medical information. We are, however, not required to agree to a requested restriction.
You have the right to request confidential communication of protected medical information by alternative means or at alternative locations.
You have the right to a copy of your protected medical information.
You have the right to amend your protected medical information, unless we did not create the record or if the record is accurate and complete.
You have the right to revoke your authorization to use or disclose medical information except to the extent that action has already been taken.
You have the right to obtain a paper copy of this notice upon request.

Our Responsibility:

Under the provisions of Federal Law (HIPPA) we are mandated to maintain the privacy of your protected medical information, provide you with this Notice of Privacy Practices, and abide by the terms of this notice.
If you have questions about this notice, or if you fee that your privacy rights have been violated, you have the right to file a written complaint with this office. You may also submit a written complaint with the U.S. Dept. of Health & Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, DC 20201. Toll Free: 1-877-696-6775.

By signing a copy of this Notice, you will certify that you have received and reviewed this notice and that all your questions have been answered to your satisfaction in language that you can understand.

Print Name of Patient	Signature of Patient or Representative	Date

First Visit Information

Chief Complaint: What led you to seek treatment today?_____

When did this begin and how did it happen? _____

Has it gotten: better, worse, remained unchanged Does it interfere with: sleep, work, daily routine, recreation

Please describe your symptoms? For example: Dull, Achy, Sharp, Burning, etc… _____

How often do you experience symptoms?
Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

Rate your current pain on a scale from 0 (no pain) to 10 (worst pain) _____

Do your symptoms change in quality and/or severity throughout the day?_____

What aggravates your symptoms?_____

What makes you feel better? (ex: heat, cold, stretching, body position, etc…) _____

Have you seen any other Health Care Providers for **this** condition and what testing has been done (Xray, labs, MRI)? _____

Who is your primary care physician _____

What is your short term wellness goal (between this visit and a month)?
_____

What is your long term wellness goal?_____

Please list your current:

Medications:

Herbs /Supplements /Homeopathics:

Environmental /Food /Drug Allergies:

Family History
Please note any family history of illness

What is your exercise routine?
_____

Caffeine? Yes No ____ drinks per week

Do you drink water? Yes No ____ drinks per day

In your daily diet, please rate the following:
Salt intake high low normal not sure
Fat intake high low normal not sure
Starch intake high low normal not sure
If you follow any diet regimes /restrictions, please describe:
_____

Patient Initals: _____

Rate your: (0=none, 1=low, 10=high)
Stress level
0 1 2 3 4 5 6 7 8 9 10
Energy level
0 1 2 3 4 5 6 7 8 9 10

Do you fall asleep easily? Yes No
Do you wake during the night Yes No
How many times? _____
Do you easily fall back asleep? Yes No
Do you wake well rested? Yes No
Do you become drowsy /low energy during the day? Yes No
How many hours do you sleep per night? _____

Medical History

CIRCLE "YES" TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Anemia/ Bruise easy	YES	Herniated Disc	YES	Sleep issues	YES
Allergy Seasonal	YES	Hernia	YES	Smoking	YES
Arthritis	YES	High blood pressure	YES	Stroke	YES
Asthma/ Wheeze	YES	High Cholesterol	YES	Surgery	YES
Breast Lump	YES	Indigestion /Heartburn /GERD	YES	Swollen ankles	YES
Bronchitis/ Pneumonia	YES	Infection - freq	YES	Thyroid Problems	YES
Bloating/ Gas	YES	Kidney Disease	YES	Tired/ Hard to get going	YES
Broken bones	YES	Kidney Stones	YES	Tonsillitis	YES
Cancer	YES	Liver Disease	YES	Tremor /Hand Shaking	YES
Cataracts	YES	Loss of appetite	YES	Tuberculosis	YES
Chronic fatigue	YES	Migraine Headache	YES	Tumors, Growths	YES
Chemical Dependency	YES	Moodiness -excessive	YES	Ulcers	YES
Constipation -freq	YES	Muscle Weakness	YES	Urinary Infection -freq	YES
Diabetes	YES	Nervous /Depression	YES		
Diarrhea – freq	YES	Night Sweats	YES	Other_____	
Dizziness – freq	YES	Numbness	Yes	Other_____	
Emphysema	YES	Osteoporosis/ 'Osteopenia	YES	**FEMALES**	
Ear infections	YES	Pacemaker	YES	Are pregnant? YES NO	
Epilepsy /Seizures	YES	Pinched Nerve	YES	Is our menstrual flow:	
Gall bladder prob/ removed	YES	Prostate Problems	YES	Regular Irregular Stopped	
Glaucoma	YES	Psoriasis /Eczema	YES	Do you have:	
Goiter	YES	Rashes /hives	YES	Pain Cramps Clotting Hot flashes	
Gout	YES	Recent weight loss	YES	____Days of flow _____Length of Cycle	
Heart Disease	YES	Rheumatoid Arthritis	YES	The first day of your most recent period was	
Headaches – freq	YES	Rheumatic Fever	YES	what date? _____	
Head injury	YES	Scarlet Fever	YES	Please list any birth control methods you are	
Hepatitis /Jaundice	YES	Shortness of Breath	YES	using: _____	

Patient initials: _____

PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please answer each section by circling the one choice that most applies to you. We realize that you may feel that more than one statement may relate to you, but

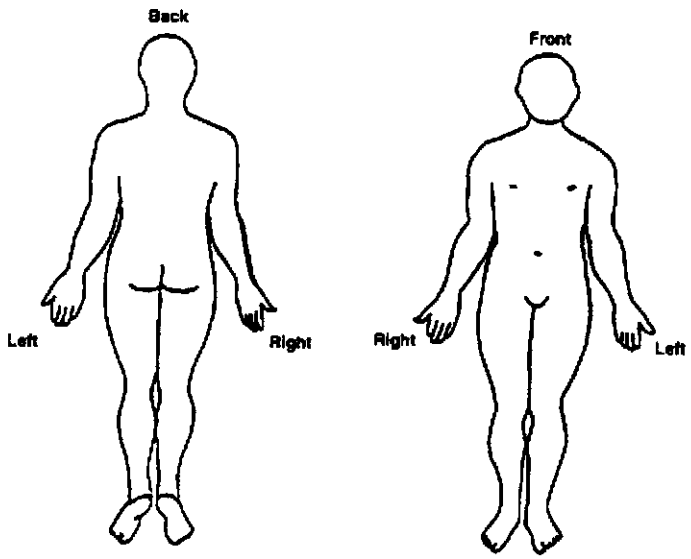
PLEASE CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW

SECTION 1 – Pain Intensity A – I have no pain at the moment. B – The pain is very mild at the moment C – The pain is moderate at the moment. D – The pain is fairly severe at the moment. E – The pain is very severe at the moment. F – The pain is the worst imaginable at the moment.	SECTION 6 – Standing A – I can stand as long as I want without extra pain B – I can stand as long as I want but it gives me extra pain C – Pain prevents me from standing for more than 1 hour D – Pain prevents me from standing for more than 30 minutes E – Pain prevents me from standing for more than 10 minutes F – Pain prevents me from standing at all
SECTION 2 – Personal Care (Washing, Dressing, etc.) A – I can look after myself normally without causing extra pain B – I can look after myself normally, but it causes extra pain C – It is painful to look after myself and I am slow and careful D – I need some help, but manage most of my personal care E – I need help every day in most aspects of self care F – I do not get dressed, I wash with difficulty and stay in bed	SECTION 7 - Sleeping A – My sleep is never disturbed by pain B – My sleep is occasionally disturbed by pain C – Because of pain I have less than 6 hours sleep D – Because of pain I have less than 4 hours sleep E – Because of pain I have less than 2 hours sleep F – Pain prevents me from sleeping at all
SECTION 3 - Lifting A – I can lift heavy weights without extra pain B – I can loft heavy weights, but it gives extra pain C – Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table D – Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned E – I can lift very light weights F – I cannot lift or carry anything at all	SECTION 8 – Social Life A – My social life is normal and gives me no extra pain B – My social life is normal but increases the degree of pain C – Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport D – Pain has restricted my social life and I do not go out as often E – Pain has restricted my social life to my home F – I have no social life because of pain
SECTION 4 - Walking A – Pain does not prevent me walking any distance B – Pain prevents me from walking more than 1 mile C – Pain prevents me from walking more than ½ mile D – Pain prevents me fro walking more than 100 yards E – I can only walk using a stick or crutches F – I am in bed most of the time	SECTION 9 - Traveling A – I can travel anywhere without pain B – I can travel anywhere but it gives me extra pain C – Pain is bad but I manage journeys over two hours D – Pain restricts me to journeys of less than one hour E – Pain restricts me to short necessary journeys under 30 minutes F – Pain prevents me from traveling except to receive treatment

SECTION 5 - Sitting	SECTION 10 – Changing Degree of Pain
A – I can sit in any chair as long as I like B – I can only sit in my favorite chair as long as I like C – Pain prevents me sitting more than one hour D – Pain prevents me from sitting for more than 30 minutes E – Pain prevents me from sitting more than 10 minutes F – Pain prevents me from sitting at all	A – My pain is rapidly getting better B – My pain fluctuates but overall is defiantly getting better C – My pain seems to be getting better but improvement is slow at present D – My pain is neither getting better nor worse E – My pain is gradually worsening F – My pain is rapidly worsening

Please draw the location of your pain on the body outlines using the symbols given to indicate the type of pain.
Mark the severity of your pain right now on the lines below the diagrams.

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^^^^^^ ^^^^	= = = = = = = = = = = =	000000 0000	. . . .	//////// ////	xxxxx xxx



No Pain ——————————— Worst Pain Possible

Please make a slash through this line as to the level of your pain.

Patient's Signature _____ Date: _____

Cancellation policy for the offices of Dr. Jaime Lubelczyk and Dr. Jenna Mooney

To keep overhead low and care quality high, the practitioners of this office have chosen not to hire office support. With that, we are unable to manage last minute cancellations and waitlists in a timely manner. We wish to continue to provide quality care by treating **only you** during your timeslot when you come in for treatment. Unfortunately, this requires a more stringent cancellation policy.

Please read and initial:

1. Appointments not canceled 24 hours prior to the scheduled appointment time are subject to a $80.00 fee.
Initial:_____

2. While we understand emergencies and illness are a part of life, notification of your inability to make your appointment is required. If you do not notify us, an $80.00 no-show fee will be added to your account and will need to be paid prior to your next treatment session.
Initial:_____

3. Text reminders are a courtesy. Please make a plan for a "self-reminder". The auto-text reminder systems are not always timely and sometimes text reminders are not sent at all. Please understand, not getting the reminder text will not be considered a valid reason for missing an appointment at this office.
Initial:_____

4. After two no-show or two late-cancellations, pre-payment for your visit in the amount of $80.00 will be required in order to schedule your next appointment.
Initial:_____

We love caring for patients one at a time and want to keep our doors open treating this way. We appreciate your understanding and cooperation.

I understand and accept the cancellation policy:

Signature:_____