WELCOME TO OUR OFFICE

(Please Print Clearly)

Name:____ Age: ___________
LAST *FIRST* *MIDDLE INITIAL*

Street: ______________________________City__________________State_______Zip______________

Cell (_____)__________________ Phone Carrier _____________ Home (_____)__________________

Contact Preference—Circle One: Home Cell Text Work

Email Address:____
(PLEASE PRINT EMAIL ADDRESS CLEARLY)

Date of Birth: __________________ ☐ Male ☐ Female Social Security: _________-_______-_________

Occupation: ____ Student: ☐ full time ☐ part time

Employed By ____ Work Phone (_____)_________________

Street: ______________________________City__________________State_______Zip______________

☐ Single ☐ Married--Spouse Name: ____________________________ ☐ Divorced ☐ Widowed ☐ Separated

Insurance Plan #1: (PRIMARY) ____

Insurance Plan #2: (SECONDARY) ____

Please provide the front desk with: 1) insurance card(s), 2) driver's license so that we may make a copy for your patient file. This will allow us to verify your insurance coverage.

When we verify benefits with your insurance company over the phone we are informed this is not a guaranty of benefits. Please check your policy book to see that the information is correct.

Today's visit I intend to pay with: ☐ Cash ☐ Check ☐ Credit Card ☐ Debit Card

Medical Doctor____ Last Visit______________

Emergency Contact _________________________ Phone ________________ Relationship _____________

Whom may we thank for referring you ____
(If Radio, Please specify which station)

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I hereby authorize and direct my insurance benefits to be paid directly to myself the insured. I am financially responsible for all services. I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

Signature____Date____________________
I HAVE READ, AND AGREE TO THE ABOVE STATEMENTS.

Office use only: ___________________________

THIS IS A CONFIDENTIAL CASE HISTORY REPORT

Height: ______________________ Weight: ___________________ Do you wear: ☐ Heel lifts ☐ Sole lifts ☐ Arch supports

☐ I have never smoked ☐ Former smoker ☐ Current smoker, if so how much: ____ pk./day ____ pk./wk.

☐ I don't drink alcohol ☐ Rarely drink ☐ Social drinker ☐ Heavy drinker (_____ oz. per day/week)

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

(Columns: OCCASIONAL / FREQUENT)

GENERAL

- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or Fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE & JOINT

- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain
- ☐ ☐ Neck pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Pain, Numbness or Cramps

- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet

GASTRO-INTESTNAL

- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digestion
- ☐ ☐ Distention of abdomen
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE & THROAT

- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ear noises
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Nosebleeds
- ☐ ☐ Sinus infection

CARDIO-VASCULAR

- ☐ ☐ Hardening of arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Slow heart beat
- ☐ ☐ Swelling of ankles

RESPIRATORY

- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

SKIN

- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

GENITO-URINARY

- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inability to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY

- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstruation
- ☐ ☐ Vaginal discharge

Pregnant ☐ Yes ☐ No
Date of last period ______________
Previous miscarriages ☐ Yes ☐ No

DATE OF LAST: (Approx.)

- _________ Physical examination
- _________ Blood test
- _________ Chest x-ray
- _________ Spinal x-ray
- _________ Dental x-ray
- _________ Urine test

NONE	LIGHT	MODERATE	HEAVY
☐	☐	☐	☐ Alcohol
☐	☐	☐	☐ Coffee
☐	☐	☐	☐ Tobacco
☐	☐	☐	☐ Drugs
☐	☐	☐	☐ Exercise
☐	☐	☐	☐ Soft Drinks

HAVE YOU EVER:

- ☐ Been knocked unconscious?
- ☐ Used a crutch, or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

*Please list any prescription drugs now taken, allergies and past surgeries - ________________________________

____

____

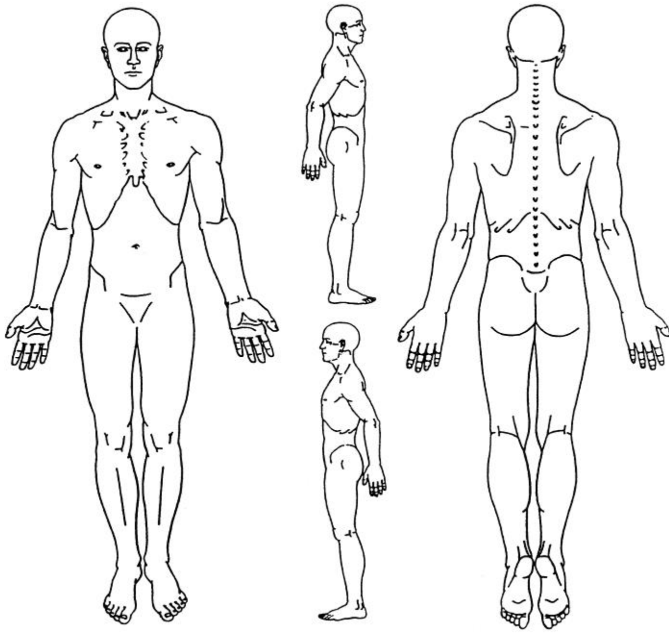
CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

☐ Aids	☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Pneumonia	☐ Tuberculosis
☐ Alcoholism	☐ Chicken Pox	☐ Foot Problems	☐ Measles	☐ Polio	☐ Typhoid Fever
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Multiple Sclerosis	☐ Rheumatic Fever	☐ Ulcers
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Mumps	☐ Scarlet Fever	☐ Venereal Disease
☐ Arteriosclerosis	☐ Emphysema	☐ Heart Disease	☐ Pacemaker	☐ Stroke	☐

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely. ***WOMEN ONLY** I hereby declare that to the best of my knowledge ☐ **I am** ☐ **I am not pregnant**. If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.

Signature____Date_____________________

Please Mark your areas of pain on the figures below.



In order of magnitude, list the areas of your body below that are affected the most.

1.______________________________________

2.______________________________________

3.______________________________________

4.______________________________________

For each of the 6 categories below, Please circle the number that best describes your typical level of activity as affected by your pain. A score of "0" means that you are Completely able to function in all of your normal activities within the category, and a score of "10" signifies that you are Completely Unable to function.

1. Family/Home Responsibilities – Activities related to the home or family, including chores and duties performed around the house (i.e. yard work), and errands or favors for family members (i.e. driving the children to school).

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

2. Recreation – Includes hobbies, sports and other similar leisure time activities.

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

3. Social Activities – Activities involving participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

4. Occupation – Activities that are a part of, or directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

5. Self-Care – Activities that involve personal maintenance and independent daily living (i.e. showering, getting dressed, driving, etc.).

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

6. Life Support Activities – Basic life-supporting behaviors (i.e. eating, sleeping, breathing, etc.).

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

Signature ______________________________ Date ______________ Total Score ________

CONSENT TO TREAT A MINOR: I hereby authorize and give consent for the Chiropractic Physicians at Mattingly Chiropractic and whomever he or she may designate as assistants to examine, and if needed, treat my minor child ____.

Print child's name here

____ ____ ______________

Printed Name | Signature of Patient/Legal Guardian | Date

Dustan J. Mattingly, D.C.

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This notice describes how Medical Information about you may be used and disclosed and how you can get access to this information. Please Review it Carefully.

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.
- We may use and disclose your health information to obtain reimbursement to you from your health plan for services you received or to obtain payment from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for service.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to request at any time a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions we will abide by our agreement (except in an emergency).

Your right to revoke your authorization

You may revoke your consent to us at any time, however your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent.

_____________________________________ _______________/____________________________

Patient Printed Name | **Date** | **Witness**

_____________________________________ _____________________________________

Patient Signature | **Patient/Guardian's Signature (if applicable)**

For Office Use Only

We have attempted to obtain written acknowledgement of receipt of our consent for use of disclosure of health information, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (specify: ____)