MATTERN CHIROPRACTIC

Dr. James C. Mattern, PC
1231 Cumberland Ave Suite D
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Phone: (765) 463-7337 Fax: (765) 497-4393

Name:_____ Today's Date:_____

Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Date of Birth:_____ Sex/Gender:_____ SS# (last four): _____

Emergency contact: _____ Phone:_____

Email Address: _____ (Doctor and client communication)

Marital Status: _____ Name of Spouse: _____

Your Job/Occupation:_____

Employer: _____

Primary Care Physician: _____( ) Ok to Send Report? ( ) Please Don't

Responsible Party if Patient is Under 18: _____

Referred By: _____

Specific Date Your complaint began:_____

Insurance Company: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Please send my appointment reminders by:

☐Text to cell phone. Cell phone carrier _____
☐Voice call to my cell phone
☐Email
☐Other_____
☐Please do not send any appointment reminders

Name: _____ **Age:** _____

Occupation: _____

What Brings You to Our Office? Please explain your complaints and symptoms.

_____

_____

_____

If injured, how did it happen? _____

_____

Circle all that apply:

What makes you better? Stand Movement Sitting Lying Down Ice Heat Medication Nothing Helps Much

What makes you worse? Lifting Coughing Movement Sitting Standing Bending

Complaint described as? Shooting Burning Intense Ache Throbbing Pins & Needles Numbness Spasms Weak Muscles Muscle "give-out" Night-time pain Nausea No relief at rest Constant Comes & goes

List all medical conditions for which you are under treatment. ( ) I have a list of medications

Condition Ex. depression					
Medication Ex. Zoloft					

List any additional vitamins, supplements, or over the counter medications you take. ( )List attached

_____

_____

_____

Major Injuries: _____

Surgeries: _____

Accidents: _____

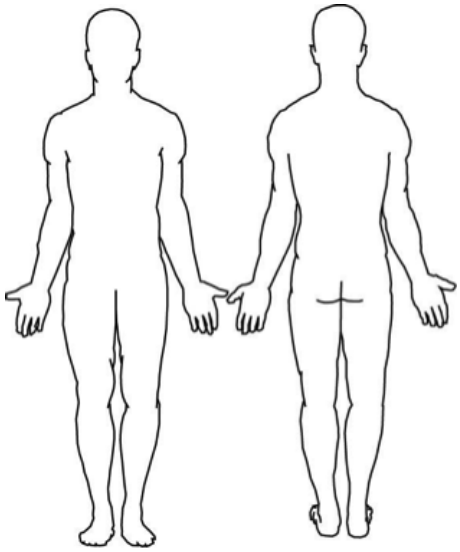
Time(s) in Hospital: _____

List your greatest stressors: on a scale of 1 to 10 (1=minimal stress, 10=great stress)

Rate Ex. 8					
Type of stress Hate job					

IN PAIN? How bad? (Circle a number)
NO Pain /0 1 2 3 4 5 6 7 8 9 10 / Worst Pain of Your Life

Shade in the picture below (as specific and precise as possible) where you feel pain or symptoms:



Height:_____ Weight: _____ lbs. This is: ( )About Right ( )Too Heavy ( )Too Thin

Have you had *unexplained* weight loss or gain of 10 pounds or more in the past month? ( ) Yes ( ) No

Do you have a history of toxic exposure to chemicals, solvents, pesticides, or heavy metals? ( ) Yes ( )No
**If yes please list below.*

_____

_____

Joint Replacements, Implants, Foreign Objects: ( )None

( )Breast ( )Hip ( )Knee ( )Shoulder ( )Glucose Pump ( )Pacemaker ( )Spinal Implant

( )Pacemaker ( )Hearing aid ( )Dentures ( )Other: _____

Recent changes/difficulty with: ( )None

( )Vision ( )Hearing ( )Taste ( )Smell ( )Balance ( )Feeling hot/cold ( )Energy ( )Strength

( )Other: _____

Allergies: ( )Yes ( )No

( )Latex ( )Shellfish ( )Wheat/gluten ( )Soy ( )Dairy ( )MSG ( )Tree nut ( )Peanut

( )Other: _____

Medical History: please circle any prior problems and star any current problems

Anxiety	Arthritis	Asthma
Autoimmune	Broken bones	Cancer
Chest pain	Depression	Diabetes
Dizziness	Epilepsy	Eye/vision problems
Fainting	Fatigue	Genetic-spinal condition
Headaches	Hearing problems	Hepatitis
High blood pressure	HIV	Joint stiffness
Menstrual problems	Heart problems	Multiple Sclerosis
Neurological problems	Pacemaker	Panic attack
Parkinson's	Prostate problems	Significant weight change
Spinal cord injury	Whiplash	Stroke/heart attack

Other: _____

Family History: F=Father M=Mother

F / M Arthritis	F / M Asthma	F / M Back Pain
F / M Cancer	F / M Depression	F / M Diabetes
F / M Epilepsy	F / M Genetic Spinal Problems	F / M High Blood Pressure
F / M Heart Problems	F / M Alzheimer's/Dementia	F / M Multiple Sclerosis
F / M Stroke	F / M Heart Attack	F / M Kidney Disease
F / M Circulation Problems	F / M Eye Disease	F / M Substance Abuse/Dependency
F / M Suicide	F / M Mental Health Issues	

Other: _____

Yes / No - I Smoke / Chew Tobacco #Number of Cigars/Cigarettes/Day _____

Yes / No - I Drink Alcohol - #Number glasses Wine/wk= ____ # Ounces Liquor/Beer/Wk=_____

cups Caffeinated Beverage/day=___ Pop/soda cans/day=____

Exercise: ( )None/minimal ( )Yes: Days/week _____ Type of Exercise: _____

Diet/Nutrition: ( ) skip breakfast ( ) Graze all day ( ) Mixed diet well-rounded
( )Lots of fast food ( )Meat and potato type ( )Vegan

Female: Pregnant? ( ) No ( ) Yes ( ) Not Sure

AUTHORIZATION AND CONSENT

For clients with possible insurance benefits, we will need to copy the front and back of your insurance card and photo ID. This courtesy helps protect all our clients from potential medical identity fraud.

Authorization and Assignment: I have attempted to give accurate responses to the prior questions. I understand that providing inaccurate answers can be a threat to my health. I authorize this office to release any information including the diagnosis and records of treatment or examination rendered to me, attorneys or representation and/or other health practitioner's services and thereafter 3rd party payers, attorneys of presentation and/or other health practitioners. I authorize and request my insurance carrier (if any) to pay directly to Dr. Mattern, PC all benefits payable for services rendered. I understand that if I have insurance, my carrier of responsibility/insured party may pay less than the actual bill for service and that I am the ultimate responsible party held accountable for the fee(s) for services and products rendered or delivered on my behalf and/or that of my dependents. I further agree that assignment of benefits and this authorization are irrevocable until monies owed Dr. Mattern, PC are paid in full.

Informed Consent to Render Care: Dr. Mattern will attempt to aid you by increasing your wellness through natural means without the use of drugs or surgery. Physical and/or nutritional therapies may be employed in an effort to aid the body in maximizing its inherent recuperative power. No specific outcome can be promised; multiple factors will dictate your response. You as a patient should secure second opinions as necessary and be mindful of the many options available in the health care arena.

Your consent allows this chiropractic physician to render care in accordance with physical findings, your history, and clinical presentation. In rare cases, underlying physical defects, anomalies, or pathologies may render you susceptible to fracture, stroke, paralysis, and other injurious state or even death. The doctor, of course, will not render care or procedures if he is aware of contraindications. Our first goal is to do no harm.

Your signature indicates you have read, comprehend, and agree to the above statements.

_____ _____

Name of Individual (Printed) Name of Individual (Signature)

_____

Date

Government Mandated – Protected Health Information and Privacy Notice

THIS IS A PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I, _____, HEREBY STATE THAT BY SIGNING THIS CONSENT, I ACKNOWLEDGE AND AGREE AS FOLLOWS:

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 Dr. James Mattern, PC, "the Practice" to provide treatment to me, and also necessary for the Practice to obtain payment for the treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future 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 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 and consent to the following: A) I may receive, to my email/home address, postcards, newsletters and/or letters discussing any balances on account, health, opportunities, products, or experiences as initiated by the Practice. B) phone, text, or answering machine contact may be initiated by the Practice for the purpose of coordinating appointment times or obtaining pertinent health care information required for record keeping or for 3rd party interaction. C) Health Care Providers and/or legal counsel may be contacted to coordinate care, diagnostics, assessments and/or clinical impression of health status, impairment, disability.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided for me) in order for the Practice to treat me and obtain payment for the treatment, and as necessary for the Practice to conduct its specific heath care operations.
5. I understand that I have the 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 (7) years. I further understand that I have the right to revoke this Consent, in writing, at any time for all further transactions, with the understand that any such revocation shall not apply to the extent that the Practice has already taken action in reliance of 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 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, the Practice will not treat me.

I HAVE READ AND UNDERSTAND THE FORGOING NOTICE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION IN A WAY THAT I CAN UNDERSTAND.

_____ _____

Name of Individual (Printed) Name of Individual (Signature)

_____ _____

Signature of Legal Representative Relationship to Patient

_____ _____

Date Witness