Office Notes Below

Name:_______________________________ Today's Date:__________ Date of Birth:___________ SS# (last four):__________

Address:____ City:________________________ State:_____ Zip:____________

Home Phone#:_________________________ Work Ph#:_________________________ Cell Ph#:__________________________

Contact who in an emergency? Name: ____ Ph#: ___________________________

Email Address:____@___________________(For Dr/Client Exchange/Education)

Your Job/Occupation:______________________ Employed@__________________ Spouse Name:________________________

Spouse Employed@____________________ List your Primary MD/Nurse Practitioner/Specialist:__________________________

____ ( ) Ok to send Report? ( ) Please Don't

Our New Clients largely come from current members. To whom may we express our heartfelt appreciation & gratitude for

referring you to our office? __________________________&__________________________&___________________________

Specific Date Your complaint began:_______________ If injured, how did it happen:____________________________________

____

List Your Complaints/What Brings You To Our Office? We need to understand your situation. In your own words. Explain how your symptoms are messing up your day.

____

____

____

Circle all that apply

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

What makes it worse? Lifting Coughing Movement Sitting Standing Bending

Complaint Described as? Shooting Burning Intense Ache Throbbing Pins & Needles Numbness Spasms

Weak Muscles Muscles "give-out" Night-time pain Nausea No relief at rest Constant Comes & Goes

List all medical conditions for which you are under treatment. List medications or ( ) I have A List of Medications

Ex: Depression			
Zoloft			

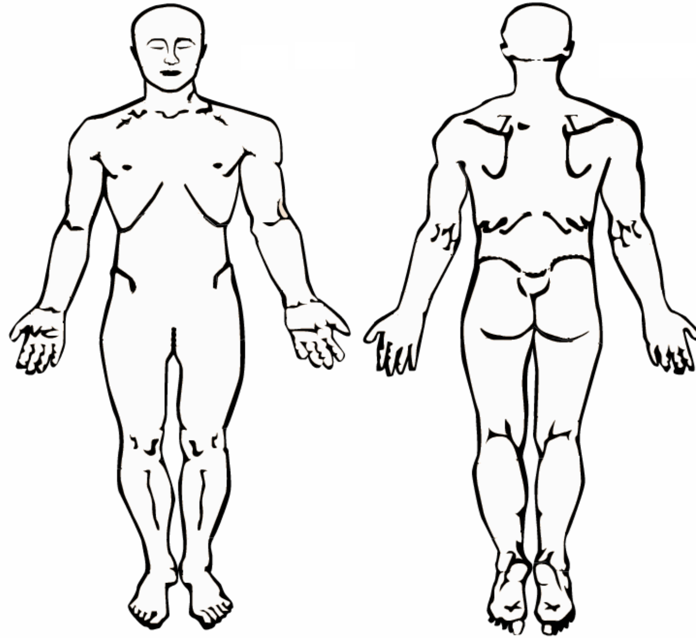
List any Over-the-Counter Medications. Product/How Often/For what Complaint?

Example Tums/3X/Week/Indigestion		

Office Notes Below

IN PAIN? How bad? (circle a number)
No Pain << 0 2 3 4 5 6 7 8 9 10 >> Worst Pain of Your Life

Specific and Precise – Shade in the picture below where you feel pain or symptom(s):



LIST…	Major Injuries	Surgeries	Accidents	Time(s) in Hospital
(example) 1983 Motorcycle Accident Broken Ribs				

LIST…Your greatest stressors…Scale: 1=minimal 10=great stress (examples: marriage, money, parenting, caregiver of aging parent, job responsibilities, restriction due to poor health, swing shift, school, etc.)

(example) 8				
Hate JOB / Last 2 yrs.				

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

What is your Height?__________ Your Weight ___________lbs This is: ( ) About Right ( ) Too Heavy ( ) Too Thin

Do you have a history of toxic exposure to chemicals/solvents/pesticides/heavy metals? (Chart below)

(examples) Lead paint in old house Lawn chemicals		

Joint Replacements/Implants/Foreign Objects: L/R ( ) breast ( ) hip ( ) knee ( ) shoulder ( ) Glucose pump

( ) Pacemaker ( ) Hearing aid ( ) Dentures ( ) spinal Implant ( ) Other ____

Any recent changes/difficulty with…
( ) Vision ( ) Hearing ( ) Taste ( ) Smell ( ) Balance ( ) Feet hot/cold ( ) Energy ( ) Strength ( ) Other

Allergies: ( ) Yes ( ) No -- I have known symptoms or reactions with exposure to the following: ( ) Latex ( ) Shellfish

( ) Wheat/Gluten ( ) Soy ( ) Dairy ( ) MSG ( ) Tree nut ( ) Peanut ( ) Other – Describe: ___________________________

Meds: ____

Dr.James C. Mattern, PC 1231 Cumberland Ave #D West Lafayette, IN 47906 Ph: (765) 463-7337 Fax: (765) 497-4393

Office Notes Below

Circle any Prior Problems You Had In The Past (Your Medical History): Ankle Pain Arm Pain

Arthritis Asthma Back Pain Broken Bones Caner Chest Pain Depression

Diabetes Dizziness Elbow Pain Epilepsy Eye/Vision Problems Fainting Fatigue

Foot Pain Genetic-Spinal Condition Hand Pain Headaches Hearing Problems Hepatitis

High Blood Pressure Hip Pain HIV Jaw Pain Joint Stiffness Knee Pain Leg Pain

Menstrual Problems Mid-Back Pain Minor Heart Problem Multiple Sclerosis Neck Pain

Neurological Problems Pacemaker Parkinson's Polio Prostate Problems Shoulder Pain

Significant Weight Change Spinal Cord Injury Whiplash Stroke/Heart Attack

ANYTHING NOT LISTED ABOVE?____

Now star (*) anything you circled that you still have ongoing trouble with in the list above.

____

Family History (Does anything "Run" in your Family?) F=Father M=Mother

F / M Arthritis F / M Asthma F / M Back Pain F / M Cancers 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

Any other risk factors we should know about?____

List ant vitamins/supplements you take:____

____or… ( ) To many to list.

Yes / No - I Smoke/Chew Tobacco # Number of Cigar/Cigarettes/Day = ___________

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

Cups Caffeinated Beverage/Day = __________ Pop/Soda Cans/Day = ____________

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

Exercise: ( ) None/Minimal….or…. ( ) Yes…. How often/Typically Doing What?______________________

Diet/Nutrition: ( ) Skip Breakfast ( ) Graze all day ( ) Mixed Diet Well Rounded

( ) Lots of Fast Food ( ) Meat and Potatoes Type ( ) Vegan

Who beside yourself is responsible for your fee for service? ( ) Just Me

( ) Medical Insurance ( ) Worker's Compensation ( ) Medicare ( ) Medicaid ( ) Auto ( ) Other

Any person responsible for insurance….parent or spouse? We need their name/DOB/Address.

____

Other insured name:____ Date of Birth:______________

Billing Address: (on card)____

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 & 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 & records of treatment or examination rendered to me, attorneys or representation &/or other health practitioners services & thereafter to 3RD party payers, attorneys of presentation &/or other health practitioners. I authorize & request my insurance carrier (if any) to pay directly to Dr. Mattern, PC all benefits payable for services rendered. I understand that I have insurance, my carrier of responsibility/insured party may pay less than the actual bill for service & that I am the ultimate responsible party held accountable for the fee(s) for service & product rendered or delivered on my behalf &/or that of my dependants. I further agree that assignment of benefits & 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 &/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 many options available in the health care arena.**

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

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

REQUIRED:____DATE________________

Authorizing Patient Signature or Said Guardian

Dr. James Mattern, PC 1231 Cumberland Ave #D W. Lafayette, IN 47906

Ph: (765) 463-7337 Fax: (765) 497-4393

Government Mandated- *Protected Health Information & Privacy Notice*

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

I,____, HEREBY STATE THAT MY SIGNING THIS CONSENT, I ACKNOWLEDGE & 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 &/or disclosures of my protected health information (PIH) necessary for Dr. James Mattern, PC, "the Practice" to provide treatment to me, & also necessary for the Practice to obtain payment for the treatment & 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 furthered explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, & 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 w/applicable law.**
3. **I understand that & consent to, the following: a) from my email/home address, I may receive postcard &/or various copy/patient newsletters discussing any balances on account/health/opportunities/products/experiences as initiated by the Practice. b) Home/work, phone, cell phone/text/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 3rd party interaction. C) Health Care Providers/& legal counsel may be contacted to coordinate care/diagnostics/assessments &/or clinical impression of health status/impairment/disability.**
4. **The Practice may use &/or disclose my PHI (which included information about my health or condition & the treatment provided for me) in order for the Practice to treat me & obtain payment for the treatment, & as necessary for the Practice to conduct its specific health care operations.**
5. **I understand that I have the right to request that the Practice restrict how my PHI is used &/or disclosed to carry out treatment, payment, &/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 (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 understanding 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 & disclosures described to me above & contained in the Privacy Notice, then the Practice will not treat me.**

I HAVE READ & UNDERSTAND THE FORGOING NOTICE, & ALL OF 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 (e.g. – Attorney-In-Fact or Parent of a Minor)

_____________ _________________________________

Date Signed Witness