

## WELCOME TO OUR OFFICE

Congratulations on your decision to join the millions of people who are enhancing their lives through regular chiropractic care. We, at Mathes Family Chiropractic, P.C., welcome you and will strive to provide you and your family with the very best corrective chiropractic care possible.

### PATIENT IDENTIFICATION

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State & Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Email: \_\_\_\_\_ Marital Status: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Name and Address of your Employer \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Hobbies/Sports/Leisure Activities you enjoy: \_\_\_\_\_

### RESPONSIBLE PARTY

Name of person responsible for this account: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State and Zip: \_\_\_\_\_

Name of employer: \_\_\_\_\_ Work #: \_\_\_\_\_

### INSURANCE INFORMATION, ASSIGNMENT AND RELEASE

This office will verify and file most insurance for you; however, we ask that today's visit be paid for in full regardless of that coverage. If it is determined that all or part of today's visit is a covered expense, a refund and/or credit will be provided to you. Please provide the Chiropractic Assistant with your card so that we can verify coverage.

I certify that I and/or my dependant(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Mathes and Mathes Family Chiropractic, P.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature below on all insurance submissions.

The above-named Doctor and his representatives may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient, Parent, Guardian \_\_\_\_\_ Date \_\_\_\_\_

Please complete other side

## ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

If you **do not** have symptoms or concerns, and are here to discover how Chiropractic care can help you optimize your health potential, please check here  and skip to number 11 on this form.

### IF YOU HAVE HEALTH CONCERNS OR SYMPTOMS:

Briefly describe your main health concerns \_\_\_\_\_

When did you first notice these concerns? \_\_\_\_\_

How did this/these concerns occur? \_\_\_\_\_

Have you had this/these concerns before? If yes, how long ago?  No  Yes \_\_\_\_\_

1. If you are experiencing discomfort or pain, is it...  
 Sharp  Dull  Burning  Comes and goes  Travels  Constant  Other \_\_\_\_\_
2. Since your concern started, it is...  About the same  Getting better  Getting worse
3. What makes it worse? \_\_\_\_\_ Better? \_\_\_\_\_
4. It interferes with:  Work  Sleep  Walking  Sitting  Hobbies  Leisure
5. Circle the pain level of current condition with 1 being "No pain" through 10 being "Unbearable pain"

Concern 1:    1   2   3   4   5   6   7   8   9   10

Concern 2:    1   2   3   4   5   6   7   8   9   10

6. Other Doctors seen for this concern (please list names):

Doctor of Chiropractic \_\_\_\_\_ M.D. \_\_\_\_\_

7. What else have you tried to correct your concern? \_\_\_\_\_

8. Please put an "X" by all symptoms you are currently experiencing and check ("√") all symptoms you have had, even if they do not seem related to your current concerns.

<input type="checkbox"/> Headaches	<input type="checkbox"/> Pins & needles in legs	<input type="checkbox"/> Fainting	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Pins & needles in arms	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Back pain	<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Stomach problems
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sinus concerns
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold Feet
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Fever	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> Lights bother eyes	<input type="checkbox"/> Asthma/Allergies/Sinus	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Menstrual pain	<input type="checkbox"/> Menstrual irregularity	<input type="checkbox"/> Cancer

9. List **all drugs** (Over-the-counter and prescription) you are taking and why? \_\_\_\_\_

10. Do you feel older than you feel you should for your current age? Yes  No

If you answered yes, how much older? (In years) \_\_\_\_\_ years.

11. What do you hope to do better or enjoy more when you regain your health? \_\_\_\_\_

12. Do you take supplements? Yes  No  (if yes, list them) \_\_\_\_\_

13. Do you exercise regularly? Yes  No  (if yes, what do you do?) \_\_\_\_\_

Please list below any previous or current health challenges that members of your family may have.

Children \_\_\_\_\_ Spouse \_\_\_\_\_

Father \_\_\_\_\_ Mother \_\_\_\_\_

The information I provided on these forms is accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and to receive appropriate care. I also clearly understand that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment at time of services rendered and/or for services not covered.

Signature \_\_\_\_\_ Date \_\_\_\_\_