# Welcome To Our Office!

We want your first visit in our office to be everything that you deserve. We strive to treat each of our practice members as though they are part of our family.

Chiropractic is a solid combination of science and the caring art of specific and gentle adjustments of the spine to remove nerve interference. Because the nerve system is the channel between your brain and every cell that makes up your body, you literally live your life through your spine and nerve system. Every aspect of your life is controlled by this very important brain/body relationship.

You will be evaluated for the presence of spinal, postural and nerve system imbalances, commonly referred to as **subluxations**. Subluxations adversely affect your health most commonly by interrupting the functional relationship of your brain/body connection.

If subluxations are detected, and we believe that we can help you, we will help you understand what is wrong, how long it will take to correct the cause(s) and how much your investment in your better health and function will be.

Many new practice members are surprised by the far-reaching results of chiropractic. Chiropractic has grown immensely because of two reasons, patient satisfaction and word of mouth. Once you experience the benefits chiropractic produces, it's hard not to share it.

Our office values each and every practice member who is committed to improving their health and we encourage you to help others by referring them to chiropractic.

If your health doesn't make you feel that now is the time of your life…it should! Health is the most valuable of all our assets and we are thankful that you have chosen us to help you regain and optimize yours.

We look forward to serving you!

Sincerely,

The Mathes Family Chiropractic Team

# WELCOME TO MATHES FAMILY CHIROPRACTIC, P.C.

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: ____________

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 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_______________

**9129 Dickey Drive Mechanicsville, VA 23116**

# 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 7 on this form.**

**What type of care are you looking for?**
____I am looking to relieve my symptoms
____I am looking to relieve my symptoms and then maintain my health
____I am looking to go beyond symptom relief by correcting the cause of my problems to achieve optimal health and wellness

**HEALTH CONCERNS AND/OR SYMPTOMS: Briefly describe your concerns in order of priority:**
**1.**______________________________________________________________________________
**2.**______________________________________________________________________________
**3.**______________________________________________________________________________

Circle the appropriate number of your concerns with 1 being "No pain" through 10 being "Unbearable pain"

**# 1:** 1 2 3 4 5 6 7 8 9 10 **# 2:** 1 2 3 4 5 6 7 8 9 10 **#3:** 1 2 3 4 5 6 7 8 9 10

When did you first notice these concerns? 1.________________2.________________3.________________
How did this/these concerns occur? 1.__________________2.__________________3.__________________
Have you had this/these concerns before? If yes, how long ago? ____No ____Yes1.______2._______3.________

**With reference to your #1 concern:**

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. Other Doctors seen for this concern (please list names):
   Doctor of Chiropractic_____________________________ M.D.______________________________
6. What else have you tried? ________________________________________________________________
7. 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.

| | | | |
|---|---|---|---|
| __ Headaches/Migraines | __Pins & needles in legs | __ Fainting | __ Neck pain |
| __ Pins & needles in arms | __ Loss of smell | __ Back pain | __Loss of balance |
| __Dizziness | __ Buzzing/ringing in ears | __Nervousness | __ Sinus |
| __Numbness in fingers | __ Numbness in toes | __ Loss of taste | __ Stomach problems |
| __ Fatigue | __ Depression | __ Irritability | __ Sinus concerns |
| __Sleeping problems | __ Stiff neck | __ Cold hands | __ Cold Feet |
| __Diarrhea | __ Constipation | __ Fever | __ Hot flashes |
| __Cold Sweats | __ Lights bother eyes | __ Asthma/Allergies | __ Heartburn |
| __Mood swings | __ Menstrual pain/irregularity | __ Shoulder pain | __ Cancer |

8. 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.
9. What do you hope to do better or enjoy more when you regain your health? _______________________________

The information I provided on this form 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.

Signature ________________________________________ Date __________________

# HEALTH HISTORY

**ALLERGIES**: Please list all allergies/sensitivities

**Food:**______________________________________________________________________________
**Medications:**__________________________________________________________________________
**Seasonal/Other:**_______________________________________________________________________

**MEDICATIONS:** Please list all medications you are currently taking and when you started

| | Medication Name | Date Started |
|---|---|---|
| Antacids | | |
| Antibiotics | | |
| Antidepressants | | |
| Anti-Diabetics | | |
| Anti-Inflammatories | | |
| Blood Pressure | | |
| Cholesterol | | |
| Hormone Replacements | | |
| Pain Medications | | |
| Other | | |

**List all surgical procedures you have had:**_________________________________________________
__________________________________________________________________________________

| **HABITS:** | **Heavy** | **Moderate** | **Light** | **None** |
|---|---|---|---|---|
| Alcohol | □ | □ | □ | □ |
| Coffee | □ | □ | □ | □ |
| Soda | □ | □ | □ | □ |
| Tobacco | □ | □ | □ | □ |
| Drugs | □ | □ | □ | □ |
| Stress | □ | □ | □ | □ |

| | **5+/wk** | **3-5x/wk** | **1-3x/wk** | **None** |
|---|---|---|---|---|
| **Exercise** | □ | □ | □ | □ |
| | **8+ hrs** | **7-8 hrs** | **6-7 hrs** | **<6hrs** |
| **Sleep** | □ | □ | □ | □ |
| **Water** | **64+ oz** | **32-64 oz** | **16-32 oz** | **<8oz** |
| | □ | □ | □ | □ |

**WORK ACTIVITY:** Heavy Labor Light Labor Mostly Sitting Mostly Standing Driving/Travel

**FAMILY HISTORY:** Identify any conditions that you or your family members have now or have had in the past:
(**G** = Grandparents, **M** = Mother, **F** = Father, **S** = Siblings, **X** = Self)

_____Alcoholism
_____Anemia
_____Cancer
_____Cold Sores
_____Deep vein thrombosis
_____Detached Retina
_____Diabetes
_____Eczema
_____Emphysema
_____Epilepsy
_____Goiter
_____Gout
_____Heart Disease
_____HIV/Aids
_____Miscarriage
_____Mumps
_____Pleurisy
_____Pneumonia
_____Polio
_____Rheumatic Fever
_____Stroke
_____Tumors
_____Ulcers
_____Other: _______________
____________________________
____________________________

The information I provided on this form 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.

Signature _______________________________________________ Date ____________________

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9129 Dickey Drive Mechanicsville, VA 23116

# TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

**Chiropractic has only one goal. It is important that each patient understands both that objective and the method that will be used to attain it. This will prevent any confusion or disappointment.**

Adjustments**: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.**

Health**: A state of optimal, physical, mental and social well-being, not merely the absence of disease and infirmity.**

Vertebral Subluxation**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.**

**We do not offer to diagnose or treat any condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.**

**Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.** OUR ONLY PRACTICE OBJECTIVE **is to eliminate a major interference (vertebral subluxation) to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.**

**I, ______________________________________________, have read and fully understand the above statements.**
**Print Name**

**Signature ____________________________________________________ Date _______________________**

## CONSENT TO EVALUATE A MINOR CHILD

I, ______________________________, BEING THE PARENT OR LEGAL GUARDIAN OF __________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to be evaluated for subluxation.

## PREGNANCY RELEASE

By my signature I certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

**Date of last menstrual period: _____________________________**

**Signature ____________________________________________________ Date _____________________**

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**Mathes Family Chiropractic, P.C.**
**9129 Dickey Drive**
**Mechanicsville, Virginia 23116**
**(804) 746-5700 fax 746-0500**

# Patient Acknowledgement and Receipt of
## Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has been offered a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _______ day of ______________________, 20_____

By___________________________________ ___________________________________
Patient's Signature Print name

If patient is a minor or under a guardianship order as defined by State law: By_______________________________
Signature of Parent/Guardian (circle one)

I give specific permission to Mathes Family Chiropractic, P.C., its employees and agents to:

use my address, phone numbers, email and/or text message to contact me with appointment reminders, missed visit appointment notification, birthday cards, holiday related cards, newsletters and/or information regarding treatment alternatives and/or other health related information,

contact me by phone, email or text and leave a phone, email or text message regarding appointments, changes in schedule, etc. if you are unavailable,

provide care in an environment where other patients are also receiving care. I am aware that other persons in the office may overhear some of my protected health information during the course of care and that should I need to speak with the Doctor at any time in private, the doctor will provide a room for these conversations,

use "travel cards" (notes regarding my care) containing private health information during the course of my chiropractic care,

and to use a sign in sheet that may be seen by others as a record of my visit to the office,

**By signing this form you are giving Mathes Family Chiropractic, P.C. permission to use and disclose your protected health information in accordance with the directives listed above.**

**Signature** _____________________________________________ **Date** ___________________

If patient is a minor or under a guardianship order as defined by State law: By_______________________________
Signature of Parent/Guardian (circle one)

**Effective September 23, 2013 and until further notice**

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