Matkin Chiropractic

727 E. Ferguson Rd. Mt. Pleasant, TX 75455

(903) 572-0212 email:drmatkin@suddenlinkmail.com

Chiropractic Case History/Patient Information

Name _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Home Phone _____ Marital: M S W D

Email Address: _____ Cell # _____ Fax# _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Employer _____

Name of Nearest Relative Not Living in Household _____ Phone# _____

How were you referred to our office? _____

Date symptoms began or accident happened _____

Have you ever had the same or a similar condition? □ Yes □ No If yes, when and describe: _____

_____

Days lost from work because of this condition _____

Family Medical Doctor _____

Date of last physical examination _____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe: _____

_____

Please check any and all insurance coverage that may be applicable in this case.

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ PIP/Med Pay □ Medical Savings
□ Medical Savings Account & Flex Plans □ Other □ None

Name of Primary Insurance Company _____

Policyholder's Name/Relation _____ SSN: _____ DOB: _____

Name of Secondary Insurance Company (If any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient/Guardian Signature _____ Date _____

NP-01-10

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Medications: Please list any medication you are taking and reason.

☐ Ibuprofen / Advil / Motrin ☐ Aleve ☐ Tylenol ☐ Aspirin ☐ Vitamins

Rx _____ Reason _____

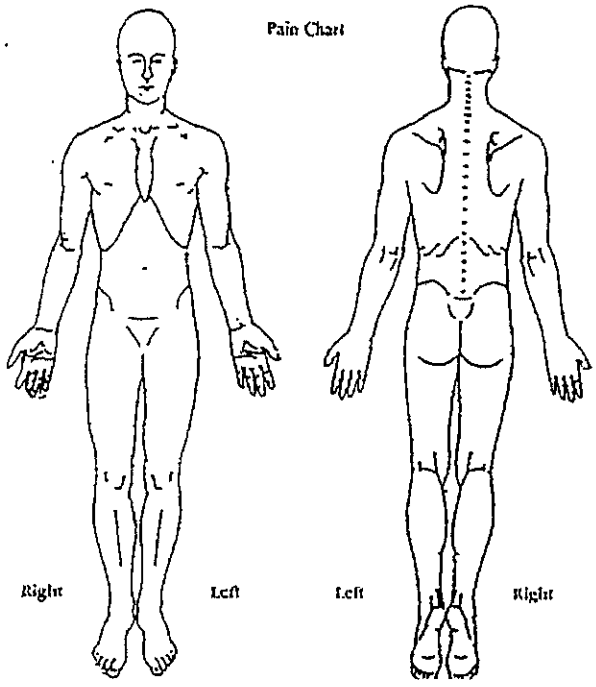
Rx _____ Reason _____

Rx _____ Reason _____

Check any of the following illnesses you have had:

☐ Asthma	☐ Osteoarthritis	☐ Rheumatoid arthritis
☐ Heart	☐ Vascular Disease	☐ Nervous breakdown
☐ Diabetes	☐ Stomach trouble	☐ Bleeding too easily
☐ Cancer	☐ Colon trouble	☐ Recurring headaches
☐ Stroke	☐ Fibromyalgia	☐ Migraine headaches
☐ High Blood Pressure	☐ Other _____	

Mark the areas on the body where you feel the described sensations. Use the following symbols. ***P*- Pain *B*-Burning *N*-Numbness *S*-Stiffness *T*-Tingling** Mark areas of radiation. Include all affected areas.



Place an "X" on the line indicating Your level of pain

Neck-Shoulder-Arm Pain

0 10

No pain Severe Pain

Mid Back Pain

0 10

No pain Severe Pain

Low Back- Leg Pain

0 10

No pain Severe Pain

_____

(Initial and date)

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1. Chief complaint or purpose of this visit _____

2. Date symptoms appeared or accident happened _____

3. What do you think caused your problem? _____

4. If this is a recurrence, when was the first time you ever noticed this problem? _____

5. What makes your problem worse? Sit Stand Lying Bending Straining Cough Sneeze Work Other _____

6. When is your problem better? Rest Medicine Mornings Moving around Other_____

7. What home treatment have you tried, and has it helped or not? _____

_____

8. List any other Doctors you have seen and their treatment (use the back if necessary)._____

_____

9. Have you had any x-rays / MRI for this problem? Yes No If yes where_____

10. What does this prevent you from doing or enjoying? _____

11. List any broken bones or major accidents/auto/falls, any time in your past._____

12. What surgeries have you had? _____

13. Have you had chiropractic care before? No Yes If yes, when_____

14. WOMEN ONLY: Are you pregnant? Yes No Number of pregnancies_____

15. Any other conditions/symptoms/remarks that you would like the doctor to be aware of? _____

_____

Patient Signature_____Date_____