Last Name: _____ **Date of Birth:** _____

Mattheson Family Chiropractic

Dr. Thomas Mattheson, D.C.
Dr. David Rivera, D.C.
812 Central Ave. Dover, NH 03820
P: (603) 742-5881 F: (603) 742-6613

Confidential Patient Health Record

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Yellow Pages ☐ Drove by ☐ Website ☐ Insurance Plan

Personal Information

Full Name: _____ Today's Date: ____ /____/_____

Date of Birth: ____ /____/_____ Age: _____ Height:_____ Weight: _____

Sex: Male / Female Social Security #: _____-_____-_____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ ext _____ Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____ ext _____ Where should we contact you first: Home Cell Work

May we leave a message for you at: Home Cell Work

Email Address: _____ (we will not share your email with any third parties)

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse Name: _____ No. of Children: _____

Favorite Hobbies/Interests: _____

Primary Care Physician/Phone Number: _____

Emergency Contact

Full Name: _____ Phone: (_____) _____-_____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Employment Information ☐ Employed Full Time ☐ Employed Part Time ☐ Retired ☐ Student ☐ Unemployed

Occupation/Job Title:_____ Business Name/Institution: _____

Accident Information

Is your condition due to an accident: ☐ No ☐ Yes Date: ____/____/_____ Time:____:____ am/pm
Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other
To whom have you made a report of your accident: ☐ Auto Insurance ☐ Employer ☐ Workers Comp
☐ Other
Attorney Name (if applicable):_____

Last Name: _____ **Date of Birth:** _____

Current Health Condition

Primary Complaint: _____

Onset: □ Gradual □ Sudden

How did it start? _____ How long ago?_____

Quality of pain? □ Aching □ Dull □ Stabbing □ Shooting

□ Numbness □ Burning □ Radiating Other: _____

How often is it present? □ 0-25% □ 26-50% □ 51-75% □ 76-100%

Pain Scale: 0 (No Pain) 10 (Worst Pain)

Current Pain: 0 1 2 3 4 5 6 7 8 9 10

At its Best: 0 1 2 3 4 5 6 7 8 9 10

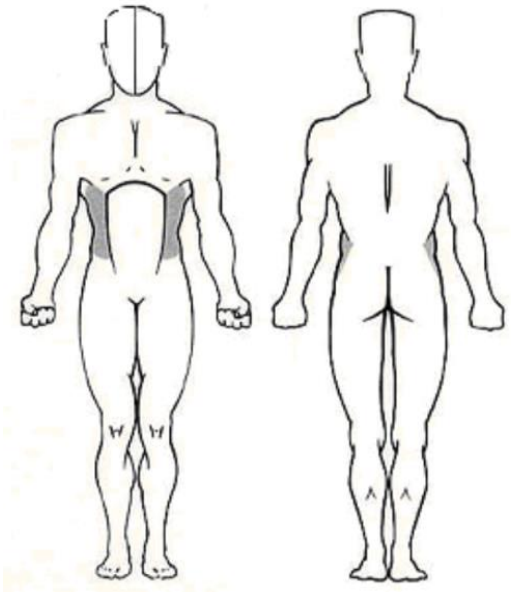
At its Worst: 0 1 2 3 4 5 6 7 8 9 10

How has your complaint changed since it started? □ Better □ Worse □ Same

Does the pain radiate anywhere? □ Yes □ No; Where? _____

What makes it feel worse? _____

What makes it feel better? _____



Please mark area of primary complaint

Secondary Complaint: _____

Onset: □ Gradual □ Sudden

How did it start? _____ How long ago?_____

Quality of pain? □ Aching □ Dull □ Stabbing □ Shooting

□ Numbness □ Burning □ Radiating Other: _____

How often is it present? □ 0-25% □ 26-50% □ 51-75% □ 76-100%

Pain Scale: 0 (No Pain) 10 (Worst Pain)

Current Pain: 0 1 2 3 4 5 6 7 8 9 10

At its Best: 0 1 2 3 4 5 6 7 8 9 10

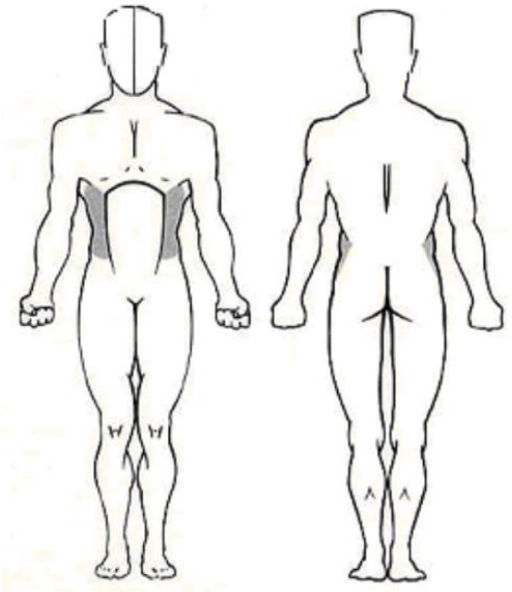
At its Worst: 0 1 2 3 4 5 6 7 8 9 10

How has your complaint changed since it started? □ Better □ Worse □ Same

Does the pain radiate anywhere? □ Yes □ No; Where? _____

What makes it feel worse? _____

What makes it feel better? _____



Please mark area of secondary complaint

Past Medical History

List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth) (next page)

Last Name: _____ Date of Birth: _____

_____ Date: ____/____/_____
_____ Date: ____/____/_____
_____ Date: ____/____/_____

List of medications you are currently on:
_____
_____

Have you ever been hospitalized for any reason other than surgery: □ Yes □ No _____

Health History

Please check the box if you have had or currently have any of the following:

□ **Abdominal pain** □ **Allergies** □ **Alcoholism** □ **Anemia** □ **Arteriosclerosis**

□ **Arthritis** □ **Asthma** □ **Back pain**

□ **Breast Lump:** Date of Last Mammogram ____/____/_____ □ **Broken bones** □ **Bronchitis**

□ **Bruise Easily** □ **Cancer: Type_____** □ **Chest pain** □ **Cold Extremities** □ **Constipation** □ **Cramps**

□ **Depression/Anxiety** □ **Diabetes: Type I Type II** □ **Difficulty Swallowing** □ **Digestion Problems**

□ **Dizziness** □ **Excessive Menstruation** □ **Excessive Thirst** □ **Eye pain or difficulties**

□ **Fatigue** □ **Headaches** □ **Hearing loss** □ **Heartburn/Indigestion**

□ **Hemorrhoids** □ **High Blood Pressure** □ **Hormone Therapy** □ **Hot Flashes** □ **Irregular Heartbeat**

□ **Irregular Menstrual Cycle** □ **Jaw/Dental Problems** □ **Kidney Infection**

□ **Kidney Stones** □ **Leg pain** □ **Loss of Balance** □ **Loss of Memory** □ **Loss of Smell**

□**Loss of Taste** □ **Nose bleeds** □ **Pacemaker** □ **Painful/Frequent Urination**

□ **Polio** □ **Poor Posture** □ **Pregnancy**

□ **Prostate Troubles:** Date of Last Prostate Exam ____/____/_____ □ **Seizures/Convulsions**

□ **Sciatica** □ **Sinus Infection** □ **Skin Problems** □ **Sleep problems/Insomnia**

□ **Spinal Curvatures** □ **Stroke** □ **Swelling of Ankles/Joints**

□ **Swollen Lymph Nodes** □ **Thyroid Condition** □ **Tremor** □ **Ulcers**

□ **Varicose Veins** □ **STD's unspecified** □ **Other:**

Females ONLY: OB/GYN Mark all that apply below.

□ I am currently pregnant	□ I am NOT currently pregnant
Please list any pertaining information related to your pregnancy:	

Last Name: _____ **Date of Birth:** _____

Social History

Alcohol: □ do not drink alcohol □ social consumption only □ drink the following regularly (mark below)
□ Beer □ liquor □ wine; quantity of _____ oz./glasses per □ day □ week □ month

Tobacco: □ **Do not use tobacco** □ Do not smoke cigars, cigarettes or pipe □ Live with a smoker □ Quit smoking
□ **Smoke:** #____ per □ Day □ Week □ Month; □ **Chew:** #_____cans per □ Day □ Week □ Year

Family History

Please include information about immediate family members, brothers, sisters, parents, grandparents.

Relationship **Present and Past Health Problems**

_____

_____

_____

Previous Chiropractic Care: □ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____
Were you satisfied with your care? □ Yes □ No. Why? _____
Do you wear any of the following? □ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics □ Other_____
For how long? _____ Were they prescribed by a doctor? □ Yes or □ No

---

I have read and understand the included information and certify it to be true and accurate.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I hereby authorize the doctor to treat my condition as he or she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negative will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Print Name: _____ Patient's Signature: _____
Date: _____
Consent to treat a Minor: _____ Date: _____
Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____

Last Name: _____ **Date of Birth:** _____

HIPAA Privacy Notice

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature: _____ Date: _____