Matthews Family Chiropractic

Dr. John J. Hanna, Director
Windsor Square 9808 Northeast Parkway Matthews, NC 28105 (704) 845-0699

CASE HISTORY

PLEASE PRINT

Name:_____ Home Phone: _____

Address:_____ City:_____ Zip: _____

Age:_____ Birthdate:_____ Marital Status: ☐M ☐S ☐W ☐D Number of Children:_____

Names of Children: _____Occupation:_____

Employer:_____Primary Phone #:_____ Mobile #:_____

Mobile Service Provider:_____ Email Address: _____

Name of Spouse or Guardian:_____Cell Phone #: _____

Occupation:_____Employer: _____ Name of Nearest Relative NOT Living

With You: _____ Phone #: _____ Referred

By:_____Date of Last Physical Exam: _____

If you have ever suffered from the following symptoms or do so currently, please check the appropriate box ("P" = in the past, "C" = currently):

	P	C
Fractured bones	☐	☐
Auto Accidents		
____ 0-1 years ago		
____ 1-5 years ago		
____ 5 years or more		
Other accidents, falls	☐	☐
Arthritis	☐	☐
Diabetes	☐	☐
Convulsions, Epilepsy	☐	☐
Skin Problems	☐	☐
Cancer	☐	☐
Frequent Colds, Flu	☐	☐
Depressed	☐	☐
Irritable	☐	☐
Anemia	☐	☐
Allergy, Sinus	☐	☐
Under Stress	☐	☐
Eating Disorders	☐	☐
Trouble Sleeping	☐	☐
Trouble Concentrating	☐	☐
Learning Disability	☐	☐
Mood Changes	☐	☐

	P	C
Neck Pain or Stiffness		
R ☐ L ☐	☐	☐
Numbness, Tingling, Pain in		
Arms, Hands, Fingers		
R ☐ L ☐	☐	☐
Jaw Pain or Click (TMJ)		
R ☐ L ☐	☐	☐
Difficulty in Excessive Standing,		
Sitting, Riding, Bending, Lifting,		
Twisting	☐	☐
Shoulder Pain R ☐ L ☐	☐	☐
Dizziness	☐	☐
Ringing in Ears R ☐ L ☐	☐	☐
Hearing Loss	☐	☐
Blurred or Double Vision	☐	☐
Upper Back Pain, Stiffness	☐	☐
Mid Back Pain, Stiffness	☐	☐
Lower Back Pain/Stiffness	☐	☐
Pain with Cough, Sneeze	☐	☐
Hip Pain R ☐ L ☐	☐	☐
Headaches	☐	☐

	P	C
Numbness, Tingling, Pain in		
Buttocks, Legs, Feet, Toes		
R ☐ L ☐	☐	☐
Foot Trouble	☐	☐
Chest Pain, Asthma	☐	☐
Heart Problems	☐	☐
Stroke	☐	☐
High/Low Blood Pressure	☐	☐
Varicose Veins	☐	☐
Liver Trouble	☐	☐
Gall Bladder Trouble	☐	☐
Digestive Problems	☐	☐
Ulcers	☐	☐
Hemorrhoids	☐	☐
Prostate Problems	☐	☐
Impotence	☐	☐
Kidney Trouble	☐	☐
Menstrual Problems, PMS	☐	☐
Bedwetting	☐	☐
Ear Infections	☐	☐
AIDS, HIV	☐	☐

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Previous Chiropractic Care? ☐ Yes ☐ No Chiropractor's Name: _____

What was the reason for your initial visit? _____

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

_____

Did you follow it?_____ If not, why? _____

Why are you changing chiropractors? _____

Have you been treated for any health condition by a physician in the last year? _____

Describe: _____

What surgeries have you had? _____

List drugs you now take (prescription and non-prescription): _____

_____

What are your health goals? _____

How do you expect to achieve these goals? _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment:_____

Method of payment you plan to use to take care of today's charges: Cash Check Visa/Mastercard Amex Are you insured? ☐ Yes ☐ No

Company Name: _____

Please show all I.D. Cards to the receptionist.

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician.

Patient's Signature:_____ Date:_____

I understand and agree that health and accident insurance policies are an arrangement between an **insurance carrier and myself**. Furthermore, I understand that Matthews Family Chiropractic will prepare any necessary reports and forms as a courtesy to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Matthews Family Chiropractic will be credited to my account on receipt. *However*, **I clearly understand and agree that all services rendered me are charged directly to me regardless of insurance, and that I am personally responsible for payment.**

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be ***immediately due and payable.*** I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Matthews Family Chiropractic to obtain a credit report if deemed necessary.

Patient or Guardian Signature:_____ Date:_____

Card #: _____ Expiration Date:_____

Prior to answering the following questions, please read the pamphlet entitled "Subluxation" on the last page.

Patient:_____ Date:_____

PATIENT HISTORY

1. What is your **main complaint**? _____

2. Vertebral Subluxations can cause irritation to different fibers within nerves. On the scale below, please **circle** the **severity** of your **main complaint** (at its worst)"

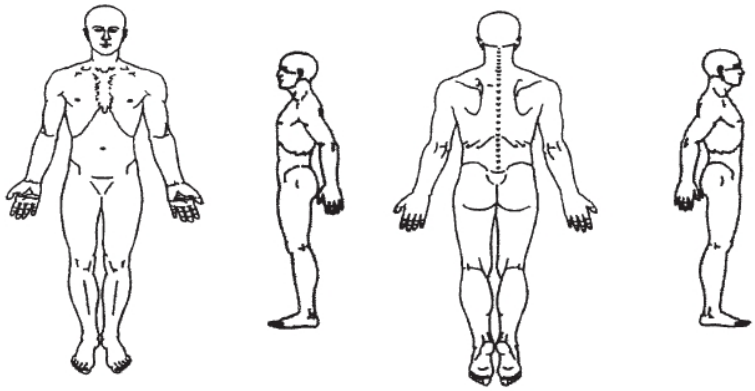
None		*Slight*		*Mild*		*Moderate*				*Severe*
1	2	3	4	5	6	7	8	9	10	

3. Subluxations can put pressure on the spinal cord which can be constant or occasional. On the scale below, please **circle** the **percentage of time** you experience your **main complaint**:

	Occasional			*Intermittent*			*Frequent*			*Constant*
0	10	20	30	40	50	60	70	80	90	100 %

4. How **long** have you been experiencing your **main complaint**?_____ Date of onset: _____

5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:
A: Ache **B**: Burning Pain **C**: Cramping **D**: Dull Pain
R: Throbbing Pain **N**: Numbness **T**: Tingling **S**: Sharp



6. Pressure on the spinal cord or nerves can be worse in t☐ AM☐ PM.
When do you notice it most?☐AM☐PM
How long does it last?____ Mins _____ Hrs.

7. What makes it feel better? _____

8. What makes it feel worse? _____

9. Have you ever had this problem in the past?☐Yes☐No

10. I have☐been hospitalized☐been treated by another chiropractor
☐been treated by another specialty provider
☐never received care for this problem
(Drs. names:_____)

11. Have you lost time from work because of it?☐Yes☐No
Dates: _____ to _____

12. Are you pregnant?☐Yes☐No

13. What was the first day of your last menstrual cycle?_____

14. Number of pregnancies? _____ Miscarriages?_____

Do you have pain and/or **difficulty** performing any of the following activities: (Check)

Personal Care_____

Lifting_____

Reading_____

Concentrating_____

Work_____

Driving_____

Sleeping_____

Recreation_____

Walking_____

Sitting_____

Standing_____

Social Life_____

Signature:_____

Date:___/___/___

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: _____ Hour _____ AM ☐ PM ☐ Location_____

How did accident occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other _____

If not an auto collision, please describe the circumstances: _____

_____

_____

_____

Did you report the injury to your foreman or employer? ☐ Yes ☐ No

Did he (they) recommend care at our office? ☐ Yes ☐ No

If an auto accident, were you: ☐ Driver ☐ Passenger ☐ Pedestrian

If auto collision, were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked

Did your car strike the other(s) involved? ☐ Yes ☐ No

OR did the other car strike yours? ☐ Yes ☐ No ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ Yes ☐ No

To the driver of the other car? ☐ Yes ☐ No

To the driver of your car? ☐ Yes ☐ No

List the extent of the injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

- ☐ Headache
- ☐ Neck Pain
- ☐ Neck Stiff
- ☐ Sleeping Problems
- ☐ Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Head Seems Too Heavy
- ☐ Pins and Needles in Arms
- ☐ Pins and Needles in Legs
- ☐ Numbness in Fingers
- ☐ Numbness in Toes
- ☐ Shortness of Breath
- ☐ Fatigue
- ☐ Depression
- ☐ Light Bothers Eyes
- ☐ Loss of Memory
- ☐ Ears Ring
- ☐ Face Flushed
- ☐ Buzzing in
- ☐ Ears Loss of
- ☐ Balance
- ☐ Fainting
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Diarrhea
- ☐ Feet Cold
- ☐ Hands Cold
- ☐ Stomach Upset
- ☐ Constipation
- ☐ Cold Sweats
- ☐ Fever

Symptoms other than above: _____

Have you lost any days of work? ☐ Yes ☐ No Dates _____

Insurance Companies Involved:

My Company: _____

Company of person responsible for injuries: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I (we) hereby request consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or the patient names below, for whom I am legally responsible: _____), by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic, Dr, John Hanna and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. John Hanna and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedures which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any conditions(s) for which I seek treatment at this facility.

Female Patients: By my signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

To be completed by the patient:	To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated):
_____	_____
Patient's Name (Print)	Print Name of Representative
_____	_____
Signature of Patient	Relationship/authority if not signed by Patient
_____	_____
Date	Date

SUBLUXATION

How abnormal position of the spine and subluxation (misalignment) can affect your health

Subluxation:

1. A misaligned spinal bone (vertebrae) which causes compression, tension, irritation, and damage to the Central Nervous System [The Central Nervous System is made up of the brain, spinal cord, and spinal nerves. The Central Nervous System totally controls all functions and healing in the human body].

2. Causes interference of the Central Nerve System.

3. Causes the organs and muscles of the body to malfunction and heal poorly due to the interference they create in the Central Nervous System.

Malfunction in the body and poor healing result in lowered resistance to infection, allergies, illness, and disease.

SUBLUXATIONS are caused by a lifetime of stress and trauma. Slips, falls, auto accidents, sports injuries, poor posture, bad sleeping habits, stress at work, or even childhood mishaps and the birth process itself can cause the spinal cord to move out of its normal position.

The Central Nervous System totally controls all the functions and healing in the body. The most common and likely way to interfere with the Central Nervous System is any abnormal position of the spine or **SUBLUXATION** (misalignment).

Symptoms are the body's warning signals that something has been malfunctioning for some time and has needed attention. In most cases, **SUBLUXATION** is present without symptom or warning. Usually, **SUBLUXATION** has existed for many years by the time a symptom arrives.

The purpose of a Chiropractic evaluation in our office is to find out if **SUBLUXATION** is interfering with your Central Nervous System causing malfunction. If we find **SUBLUXATION** on your exam, nerve tests, and/or x-rays studies WE CAN HELP YOU!