Case #______

PATIENT INFORMATION

Please allow our staff to photocopy your driver's license and all available insurance cards.
WELCOME! PLEASE PRINT.

Full Name____ Gender: M F Home Phone ____________________
Address____________________________________City______________State_________Zip______________
Age_______________Birth Date___________Marital Status (Circle One): S M W D Sep No. Children______
SS#_______________________________ Driver's License # ____
Your Employer ___________________________ Your Occupation ________________Years on Job________
Employer Address______________________________City_____________State____________Zip________
Work Phone___________________________________Cell Phone__________________________________
Do you have health insurance where you work? ☐ Yes ☐ No Plan/Group #____________________________
Insurance Company____
Name of Spouse, Parent or Guardian_______________________Age_____Birth Date_______SS#___________
Spouse's Employer________________________Spouse's Occupation__________________Yrs on Job_____
Employer Address______________________________City_____________State____________Zip________
Work Phone____
Do your spouse have health insurance at work? ☐ Yes ☐ No Plan/Group #____________________________
Insurance Company____
How did you find out about our office?____
Describe the major complaints that bring you to our office:_____________________________________
____
Is your condition due to an accident? ☐ Yes ☐ No Date of your accident: ____________________________
____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered to 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 (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider, or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.
I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature____Date_____________________________

Spouse's or Guardian's Signature__________________________________Date_____________________________

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee as time permits.

Payment Options (Please Indicate): ☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ Discover

PATIENT HEALTH SURVEY

Case # __________

FULL NAME ______________________________ AGE ________ DATE __________

Have you ever (at any time) experienced any of the following?

	Y	N
Difficulty urinating	Y	N
Loss of bladder control	Y	N
Loss of bowel control	Y	N
Temporary loss of vision, one eye	Y	N
Blood in urine	Y	N
Claustrophobia (fear of small spaces)	Y	N
Spinal surgery	Y	N
Common cold/flu	Y	N
Carotid artery surgery	Y	N
Breast removal	Y	N

Have you ever been diagnosed with or told you have one of the following?

	Y	N
Detached retina	Y	N
Stroke	Y	N
Slipped disc	Y	N
Herniated disc	Y	N
Osteoporosis	Y	N
TIA's (pin or mini strokes)	Y	N
Drop attacks (collapsing, but not fainting)	Y	N
Hardening of the arteries	Y	N
Partial or complete paralysis	Y	N
Rheumatoid Arthritis	Y	N
Fractured/broken vertebra	Y	N
Bleeding disorders	Y	N
High blood pressure	Y	N
Blood in stool	Y	N
Cancer	Y	N
AIDS	Y	N
Kidney disease	Y	N
Prostate disease	Y	N

Do you currently have, or could you be, any of the following?

	Y	N
Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy ❑ Male ❑ Female	Y	N
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs.day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants (ear)	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

In the past 14 days (2 weeks), have you experienced any of the following?

	Y	N
Nausea	Y	N
Vomiting	Y	N
Vertigo (spinning)	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness or other sensory complaints	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Used a tanning bed/booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain moving bowels	Y	N
Head trauma	Y	N
Abnormal period	Y	N

Matthews Chiropractic Clinic
4515 Office Park Dr.
Jackson, MS 39206

Case # ________

CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present.

An understanding of your health history will help us to determine appropriate care.

FULL NAME ______________________________ DATE ________

AGE ________ RACE ________ GENDER ________ HEIGHT ________ WEIGHT ________

Review of Systems

1. Do you have skin, hair or nail problems: ❑ Yes ❑ No ________
2. Do you have mouth and/or throat problems? ❑ Yes ❑ No ________
3. Do you have nose and/or sinus problems? ❑ Yes ❑ No ________
4. Do you have ear problems? ❑ Yes ❑ No ________
5. Do you have eye problems? ❑ Yes ❑ No ________
6. Do you have chest or lung (breathing) problems? ❑ Yes ❑ No ________
7. Do you smoke? ❑ Yes ❑ No Amount per day________ How Long? ________
8. Do you have heart and/or blood vessel problems? ❑ Yes ❑ No ________
9. Do you have blood or lymph node problems? ❑ Yes ❑ No ________
10. Do you have digestive problems? ❑ Yes ❑ No ________
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? ❑ Yes ❑ No ________
12. Do you have urinary (including kidney or bladder) problems? ❑ Yes ❑ No ________
13. **Females**, have you had menstrual problems? ❑ Yes ❑ No ________
    Have you ever taken birth control pills? ❑ Yes ❑ No For how long? ________
    Is there any chance that you are currently pregnant? ❑ Yes ❑ No
    Do you have any breast problems? ❑ Yes ❑ No ________
14. Do you have any nervous system diseases and/or mental health problems? ❑ Yes ❑ No
    ____
15. Do you have any gland and/or hormone problems? ❑ Yes ❑ No ________
16. Do you have allergy or immuity problems? ❑ Yes ❑ No ________
17. Do you have any muscle, tendon or ligament problems? ❑ Yes ❑ No ________
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? ❑ Yes ❑ No________
    ____

Past History

19. List any diseases which you have had in the past, including childhood diseases:________
    ____
20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.:________
    ____
21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? ❑ Yes ❑ No
    ____
    ____
22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
    ________ Date________
    ________ Date________
    ________ Date________
    ________ Date________

(OVER PLEASE)

Case # ________

CASE HISTORY
(CONTINUED)

FULL NAME ______________________ DATE ________

23. Have you ever been hospitalized for any reason other than surgery? ☐ Yes ☐ No ________
24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: ________
25. Your diet is: ☐ Balanced ☐ Fair ☐ Poor ☐ Excessive ☐ Restricted

Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? ☐ Yes ☐ No ________

Social History

27. In what position do you usually sleep, and how well? ________
28. Do you exercise on a regular basis? ☐ Yes ☐ No How? ________
29. How do you spend your spare time (hobbies, etc)? ________
30. Do you use: ☐ Caffiene? ☐ Tobacco? ☐ Nicotine? ☐ Recreational Drugs? ☐ Alcohol?
31. Please describe your work.
    Type: ☐ Professional ☐ Physical Labor ☐ Driver ☐ Clerical ☐ Factory ☐ Homemaker
    Physical Demands: ☐ Heavy ☐ Moderate ☐ Mild ☐ Sedentary
    Stress Level: ☐ High ☐ Medium ☐ Low

Additional Questions

32. Do you have problems with recurring headaches? ☐ Yes ☐ No ________
33. Are you losing weight without trying? ☐ Yes ☐ No
34. Does your pain wake you up at night? ☐ Yes ☐ No
35. Have you had a change in bowel or bladder habits? ☐ Yes ☐ No ________
36. Have you had a sore that doesn't heal? ☐ Yes ☐ No ________
37. Have you recently had any unusual bleeding or discharge? ☐ Yes ☐ No ________
38. Do you have a thickening/lump in the breast or elsewhere? ☐ Yes ☐ No ________
39. Do you have indigestion or difficulty swallowing? ☐ Yes ☐ No ________
40. Have you had an obvious change in a wart or mole? ☐ Yes ☐ No ________
41. Do you have a nagging cough or hoarseness? ☐ Yes ☐ No ________
42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.
    ____
43. Please describe your current complaint. In other words, what brought you here? ________
44. Who is your:
    Medical Doctor? ________
    OB/GYN? ________
    Dentist? ________

Case # ________

PROBLEM FOCUSED HISTORY

FULL NAME ______________________________ DATE ______________

AGE ______________ OCCUPATION ______________________________

RACE: ❑ Cauc. ❑ Black ❑ Hisp. ❑ Asian ❑ Am. Indian ❑ Other ______________ Sex ❑ M ❑ F

PATIENT/INFORMANT STATES: ______________________________

____

____

DETAILS OF CHIEF COMPLAINT:

1. **Location of Symptoms/Dysfunction:**
   In order of onset: 1 ________ 2 ________ 3 ________ 4 ________
   Intensity of pain: ________ ________ ________ ________
   (Patient's perception)
   AMA Scale: Minimal 1-3, Slight 4-6, Moderate 7-9, Marked 10
   Borg Scale: Normal 0, Low 1-3, Moderate 4-6, Intense 7-9, Emergency 10

2. **Radiation/Spread/Referral of Pain:** ❑ Y ❑ N

3. **Onset:** ______________________________
   When did it start?
   Explanation: ______________________________
   How did it start?
   ❑ WC ❑ PI ❑ MM ❑ MC ❑ C ❑ PA

   Date of First Report: ______________ Date of First Visit: ______________

4. **Type of Sensation:** ______________________________
   Quality of pain?/What does it feel like?

5. **Frequency (Timing):**
   ❑ Intermit. 0-25 ❑ Occas. 26- 50 ❑ Frequent 51-75 ❑ Constant 76-100

6. **Exacerbation/Aggravation/Increase:** ❑ Y ❑ N
   Postures, activity, time of day, etc.

7. **Symptoms/Dysfunction Since Onset Have:**
   ❑ Decreased ❑ Increased ❑ Remained About The Same ❑ Erratic

8. **Change In Bodily Functions:** ❑ Y ❑ N

❑ Balance	❑ Bowel Habits	❑ Breathing	❑ Coordination
❑ Coughing	❑ Gait	❑ Grip	❑ Hearing
❑ Menstrual	❑ Sexual	❑ Sleep	❑ Sneezing
❑ Urination	❑ Vision	❑ Weakness	❑ Weight

9. **Handedness:** ❑ L ❑ R ❑ Am.

DOCTOR'S NOTES:

1. Points To: ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

Case # ________

PROBLEM FOCUSED HISTORY
(CONTINUED)

FULL NAME ______________________________

10. **Change In Activities of Daily Living:** ❑ Y ❑ N
    What do you not do because of this problem?
    ❑ Forgotten with activity ❑ Interferes with activity ❑ Activity continues despite problem
    ❑ May prevent activity ❑ Prevents activity

11. **Work Status: No. of Jobs 1 2 3**
    ❑ Full-time ❑ Part-time ❑ Homemaker ❑ Student
    ❑ Retired ❑ Disabled ❑ Unemployed ❑ Shift 1 2 3

12. **Work/Home Disability:** ❑ Y ❑ N
    Complete: ________ Days off work
    ________ Days unable to perform household tasks
    Partial: ________ Days of job modification
    ________ Days of decreased household tasks

13. **Store-bought or Home Remedies:** ❑ Y ❑ N
    Care not recommended by a doctor.
    Type/Effect: ______________________________

14. **Other Professional Care:** ❑ Y ❑ N
    Type, Tests, Dx, Tx, Effect: ______________________________

15. **Remission/Relief/Decrease:** ❑ Y ❑ N
    Postures, activities, time of day, etc.

16. **Same or Similar Condition:** ❑ Y ❑ N
    Explanation: ______________________________

17. **Concurrent Symptoms/Conditions:** ❑ Y ❑ N
    Are you currently under a doctor's care for any other condition(s)?

18. **Do You Have A Pacemaker or Any Other Surgically Implanted Device?** ❑ Y ❑ N

19. **Are You Now or Could You Be Pregnant?** ❑ Y ❑ N

10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________
14. ______________________________
15. ______________________________
16. ______________________________
17. ______________________________
18. ______________________________
19. ______________________________

Matthews Chiropractic Clinic
4515 Office Park Drive
Jackson, MS 39206
(601)366-9005

Matthews Chiropractic Clinic
612 Sunflower Ave. Ext., Bldg. 18-B
Indianola, MS 38751
(662)887-9494

Notice of Privacy Practices
MATTHEWS CHIROPRACTIC CLINIC
Dr. Endre' Matthews, D.C.

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

How medical information about you may be used and disclosed and how you can access this information

- We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.
- We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.
- As our patient, you have important rights,relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.
- We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.
- You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.
- If you have any questions, concerns or complaints about the NOTICE or your medical Information, please contact: Dr. Endre Matthews at 601-366-9005.

I, ______________________, have read and I do understand the Notice of Privacy Practices for Matthews Chiropractic Clinic.

Patient/Guardian Name ______________________

Patient/Guardian Signature ______________________ Date __________

MATTHEWS CHIROPRACTIC CLINIC, LLC

DR. ENDRE D. MATTHEWS

4515 Office Park Drive
Jackson, MS 39206
(601)366-9005
(601)259-5206 cell phone

Email: endrematthews@hotmail.com
website:HTTP://www.webackyou.com

612 Sunflower Ave. Ext. Bldg 18B
Indianola, MS 38751
(662)887-9494

AUTHORIZATION TO PAY THE DOCTOR

This form is considered the "Authorization to Pay the Doctor". I, __________________, hereby authorize payment directly to **Matthews Chiropractic Clinic**, the office of **Dr. Endre' D. Matthews** of insurance benefits. I understand that I am responsible for all costs of Chiropractic Treatment. I hereby authorize and direct you, to pay directly to said doctor such sums as may be due and owing said doctor for medical service(s), supplies, and reports rendered to me or on my behalf, both by reason of this accident and by reason of any other bills related to this accident that are due the doctor's office and to withhold such sums from any settlement as may be necessary to adequately protect and fully compensate said doctor.

By my signature below, I hereby waive and/or relinquish my right to contend and/or otherwise make any legal objections as to the appropriateness of this agreement.

Signature of Patient ______________________________ Date ____________

Signature of Witness ______________________________ Date ____________

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Dear Patient/Provider

The owners of Matthews Chiropractic Clinic continue to work hard to convenience you. We do accept payments in cash, check, and credit card with proper identification. Checks are accepted as a convenience to you. In the case of a returned check, you, as the writer/endorser of the check, are responsible for any bounced check fees which Matthews Chiropractic Clinic charges in addition to any bank fees Matthews Chiropractic Clinic incurs due to the bounced check. Matthews Chiropractic Clinic reserves the rights to demand future payment in the form of Cash, Credit\Debit Card, or Money Order if a check that you (the patient) has written bounces.

I,____, being the payer, do understand and agree with the stipulations stated above.

Signature of Patient ________________________________ Date ____________

Signature of Witness ________________________________ Date ____________

MATTHEWS CHIROPRACTIC CLINIC

Name____ Date______________________

1. Are you experiencing any pain or discomfort today?
   Please rate your pain from 0 to 10. (Ex. 0 = no pain 10=extreme pain)

2. When did your pain begin? (date pain started)

3. What relieves your pain (makes you feel better)?

4. What worsens your pain or causes your pain?

5. Please describe your pain. (ex. Sharp, aching, nagging, throbbing, etc)

6. Does your pain move or radiate?

7. Is your pain constant or does your pain come and go? It it comes and goes, how often?

8. Are any Activities of Daily Living affected (combing hair, bending, sitting, walking, etc.)?