

Mattson Family Chiropractic

Wellness History – Health Profile

Personal Information

Date: _____

Name: _____ Date of Birth: ____ / ____ / ____ Age: _____ Male Female

Address: _____
Number & Street City State Zip

Phone (H): _____ (Cell): _____ (Work): _____

E-mail Address: _____ Marital Status: ____ Occupation: _____

Employer: _____ How many children do you have? _____ Ages: _____

Have you had previous chiropractic care? _____ Amount of time under chiropractic care: _____

Who may we thank for referring you to our office? _____

Your Health Profile

What is the main reason for your visit?

If you are here for chiropractic wellness services please skip the rest of this box and go on to the "General History" section.

Please briefly describe your condition, including the impact it has had on your life, by answering the following questions.

Rate Severity (scale 1-10, 1 being mild) _____

When & how did this start? _____

What makes the problem better?

Worse? _____

What does this interfere with? Work Sleep
 Leisure Other: _____

Have you seen other doctors for this? Yes No
 Chiropractor MD Other: _____

General History

Please list all medications you are taking:

- Cholesterol: _____
- Blood Pressure: _____
- Blood Thinner: _____
- Pain Meds: _____
- Depression/Anxiety: _____
- Diabetes Meds: _____
- Other: _____

Please list all supplements you are taking:

How regularly do you exercise? ____ X/week
 Work Activity Only Never

On a scale of 0-10 please rate your diet (0 = poor and 10 = perfect): _____

Do you use (or have you in the past used) any of the following for your health development?

- | | |
|--|---|
| <input type="checkbox"/> Massage | <input type="checkbox"/> Nutritional Counseling |
| <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Naturopathic Medicine |
| <input type="checkbox"/> Emotional Therapy | <input type="checkbox"/> Custom orthotics |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Wellness Chiropractic |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Cranial-Sacral Therapy |
| <input type="checkbox"/> Yoga/Pilates | <input type="checkbox"/> Other: _____ |

Overall Health Status

Please **check** the health concern or concerns you may be experiencing now or have experienced in the past. Each area of concern relates to an area of the spine and nerve function. (While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment, care plan, and/or the possibility of being accepted for care.)

- Sore Throat
- Stiff Neck
- Arm Pain
- Hand/Finger Numbness
- High Blood Pressure
- Heart Conditions
- Chest Pain

C5
C6
C7
T1



- Headaches
- Dizziness
- Sinus Problems
- Head Colds
- Ringing in Ears
- Difficulty Concentrating
- Migraines
- Allergies
- Fatigue
- Vision Problems
- Hearing Problems

T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

- Middle Back Pain
- Asthma
- Diabetes
- Ulcers
- Kidney Problems
- Heartburn/Indigestion
- Difficulty Breathing
- Gallbladder Issues
- Stomach Problems
- Liver Problems

- Constipation
- Colitis
- Diarrhea - Gas Pain
- Irritable Bowel
- Bladder Problems
- Low Back Pain
- Pain/Numbness in legs
- Reproductive Problems

L1
L2
L3
L4
L5
S
A
C
R
A
L

- Other Conditions:**
- Fever
 - Cancer
 - Anxiety
 - Weight Changes
 - HIV/AIDS
 - Loss of sleep
 - Other: _____
 - Sweats/Chills
 - Anemia
 - Depression/Nervousness
 - Rashes/Eczema
 - Cold Hands/Feet
 - Arthritis
- For women:**
- PMS
 - Mood swings
 - Irregular cycles
 - Currently pregnant
 - Painful periods

Stress History

On a daily basis we all experience physical, chemical and mental stresses that can accumulate and result in serious loss of health. Answering the following questions will give us an idea of the specific stresses past and present that you face and allow us to better assess the challenges to your health.

1. History of Physical Stress, Trauma or Challenges (present or past)

- Repetitive lifting /bending /typing
- Car accidents
- Serious falls
- No exercise
- Physical abuse
- Work injury
- Surgeries
- Active in sports
- Sit a lot – car/office
- Broken bones
- Alcohol or drug abuse
- Hospitalizations
- Sit on wallet
- Poor sleep/not enough sleep
- Other injuries _____

2. History of Chemical Stress, Trauma or Challenges (present or past)

- | | | |
|--|---|--|
| <input type="checkbox"/> Smoker past/present | <input type="checkbox"/> Second-hand smoke | <input type="checkbox"/> Over the counter meds |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Work with chemicals | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Drug/alcohol overdose | <input type="checkbox"/> Prescription medications | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Mercury fillings in teeth | <input type="checkbox"/> Vaccinated | <input type="checkbox"/> Other: _____ |

3. Nutritional Stresses & Choices (please check the items that apply to your typical diet)

- | | | |
|--|--|--|
| <input type="checkbox"/> Junk food (___ X's per week) | <input type="checkbox"/> No breakfast | <input type="checkbox"/> Home cooked meals (___ X's per week) |
| <input type="checkbox"/> Restaurant meals (___ X's per week) | <input type="checkbox"/> Skip meals | <input type="checkbox"/> Microwave food (___X's per week) |
| <input type="checkbox"/> Artificial sweetener | <input type="checkbox"/> Excess sugar | <input type="checkbox"/> Gluten-free |
| <input type="checkbox"/> Dairy-free | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Fruits/Veggies (___ servings per day) |
| <input type="checkbox"/> Alcohol (___ X's per week) | <input type="checkbox"/> Soda (___ X's per week) | <input type="checkbox"/> Water (# of glasses per day ___) |
| <input type="checkbox"/> Coffee/caffeine (___ X's per week) | <input type="checkbox"/> Energy drinks | <input type="checkbox"/> Other special diet: _____ |

4. History of Mental/Emotional Stress, Trauma or Challenges (present or past)

- | | | |
|--|--|---|
| <input type="checkbox"/> Recurrent physical/mental illness | <input type="checkbox"/> Hold in feelings | <input type="checkbox"/> Quick tempered |
| <input type="checkbox"/> Made fun of/teased | <input type="checkbox"/> Loss of loved one | <input type="checkbox"/> High family stress |
| <input type="checkbox"/> Body image issues | <input type="checkbox"/> Poor self-esteem | <input type="checkbox"/> High personal stress |
| <input type="checkbox"/> Mental/emotional/sexual abuse | <input type="checkbox"/> Alcohol or drug abuse | <input type="checkbox"/> High job stress |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Money stress | <input type="checkbox"/> Difficult divorce/break-up |
| <input type="checkbox"/> Other: _____ | | |

Do you relate any of the stresses or traumas you checked above (sections 1 - 4) to your current state of health? Yes No If yes, which ones? _____

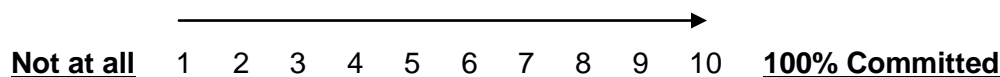
Your Goals

What do you hope to receive from our care? _____

Which of the following would you like to achieve:

- | | | |
|--|---|---|
| <input type="checkbox"/> Get fit | <input type="checkbox"/> Eat better | <input type="checkbox"/> Reduce stress |
| <input type="checkbox"/> Stop smoking | <input type="checkbox"/> Reduce pain | <input type="checkbox"/> Increase my mobility |
| <input type="checkbox"/> Improve my posture | <input type="checkbox"/> Improve my sleep | <input type="checkbox"/> Lose weight |
| <input type="checkbox"/> Learn about wellness | <input type="checkbox"/> Improved quality of life | <input type="checkbox"/> Ability to make better lifestyle choices |
| <input type="checkbox"/> Learn about wellness products that are right for me | | |

How committed are you to actively participating in moving yourself toward greater levels of happiness, peace, health and well-being? (Circle your answer)



Notice of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Understanding Our Service

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Subluxations are patterns of tension stored in the body causing an alteration of nerve function.

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

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, 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 to the expression of the body's innate wisdom.

Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and the patient. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Who should receive bills for payment on your account? Patient Spouse Parent Health Insurance
Name of Insured Individual: _____ Insured's Date of Birth: _____

Ownership of X-ray Films: It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

I agree to the Privacy Policy, the Terms of Acceptance and Authorization For Care:

Signature: _____ Date: _____

Patient Case History

For Office Use

Do Not Write

Main Concerns: _____

Cervical: _____ Thoracic: _____

Lumbar: _____ Sacral: _____

History of Condition:(Most recently): _____

Associated Symptoms: _____

Aggravating Factors: Sitting Standing Sleeping Getting up from sitting Other: _____

What has been done to help this condition? Heat Ice Medications: _____

Other: _____

Prior surgeries/Hospitalizations: _____

Accidents: _____

Other Illnesses: _____

Family Health History: **HBP:** Mother/Father **Heart Disease:** Mother/Father **Diabetes:** Mother/Father
Thyroid: Mother/Father **Stroke:** Mother/Father **Cancer:** Mother/Father **Other:** _____

STRESS: Above Average Average (Review "Stress History") _____

MEDICATIONS: (review section under "General History") _____

LIFESTYLE: (review section under "General History") _____