# WELCOME!

Matz Family Chiropractic, P.C. extends a warm and personal welcome to you on behalf of the staff and doctors. Our goal is to provide you with the finest health care as well as offer you many informative and entertaining educational opportunities.

**WHAT TO EXPECT:**

**FIRST VISIT** • Consultation • Exam • X-Rays (if indicated)

**SECOND VISIT** • Video and report of health findings
• Specific chiropractic adjustment

**SPINAL HEALTH CARE CLASS** • Important to understand your health care needs

# HEALTH HISTORY

NAME _____ GENDER: FEMALE _____ MALE _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (_____)_____ WORK PHONE (_____)_____ CELL (_____)_____

DATE OF BIRTH _____ AGE _____ HEIGHT _____ WEIGHT _____

RACE: AMERICAN INDIAN AFRICAN AMERICAN WHITE ASIAN OTHER DECLINE

ETHNICITY (circle one) HISPANIC NON HISPANIC

E-MAIL _____

EMPLOYER _____ ADDRESS _____

YOUR SOCIAL SECURITY NUMBER _____ MARITAL STATUS S M D W

SPOUSE'S NAME _____ D.O.B._____ SPOUSE'S EMPLOYER_____

WORK PHONE (_____)_____ IF CHILD, PARENT'S NAMES _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE (_____)_____

WHO REFERRED YOU TO OUR OFFICE? _____

MAJOR COMPLAINT _____

PAIN OR PROBLEM STARTED ON _____ IS THIS DUE TO AN ACCIDENT? _____

DATE AND TYPE OF ACCIDENT _____

PAINS ARE: SHARP DULL CONSTANT INTERMITTENT

IS THIS CONDITION INTERFERING WITH WORK? SLEEP? ROUTINE?

OTHER DOCTORS SEEN FOR THIS CONDITION? _____

ANY HOME REMEDIES? _____

| INJURIES / SURGERIES YOU HAVE HAD | DESCRIPTION | DATE |
|---|---|---|
| | | |
| | | |

**Preferred method of communication for patient reminders** (Please Check One)

☐ E-mail **E-mail address:** _____@_____

☐ Text **Cell Phone Number** _____

**Cell Phone Provider Needed for Text** (Circle one): Verizon / AT&T / Other: _____

☐ No Reminder

**Continue on back**

**Other Symptoms:**

___ Headaches
___ Migraines
___ Neck Pain
___ Sleeping Problems
___ Back Pain
___ Nervousness
___ Tension
___ Irritability
___ Chest Pain
___ Dizziness
___ Face Flushed
___ Neck Stiff
___ Heavy Feeling of Head
___ Hip Pain
___ Decreased Appetite
___ Twitches
___ Pins & Needles in Legs
___ Pins & Needles in Arms
___ Numbness in Fingers
___ Numbness in Toes
___ Shortness of Breath
___ Fatigue/Lack of Energy
___ Depression
___ Lights Bother Eyes
___ Blurred Vision
___ Double Vision
___ Loss of Memory
___ Eye Difficulty
___ Hyperactivity
___ Decreased Attention
___ Ear Ring
___ Fever
___ Bed Wetting
___ Asthmatic Symptoms
___ Skin Disorder
___ Acne
___ Fainting
___ Loss of Smell
___ Loss of Taste
___ Diarrhea
___ Feet Cold
___ Hands Cold
___ Hemorrhoids
___ Increased Sweating
___ Seizures
___ Stomach Upset
___ Indigestion
___ Heart Burn
___ Constipation
___ Cold Sweats
___ Loss of Balance
___ Buzzing in Ears
___ Decrease in Hearing
___ Sinus Difficulties
___ Reoccurring Infections
___ Ear Infections
___ Reproductive Difficulties

**For women only:** Are you pregnant? ☐ Yes ☐ No _____ Due Date _____

## Are you currently taking medications? (Attach additional sheet if needed)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |

## Do you have any medication allergies?

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |

Are there any hereditary health issues that you know about? _____ + _____

_____

**EXERCISE**
___ None
___ Moderate
___ Daily
___ Heavy

**WORK ACTIVITY**
___ Sitting
___ Standing
___ Light Labor
___ Heavy Labor

**HABITS**
___ Smoking
___ Alcohol
___ Coffee/Caffeine Drinks
___ High Stress Level

Circle One Have you ever smoked? Yes No Do you smoke? Yes No

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

## INSURANCE INFORMATION

Do you have insurance? ___Yes ___ No

**Please check one and <u>give your card to the front desk for copying</u>**

Policy Holder's Name: _____ Policy Holder's DOB: _____

Insurance Company's Name: _____ Policy Holder's SS # _____

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I give authorization to **Matz Family Chiropractic, P.C.** for my treatment.

_____
Responsible Party Signature

_____ _____
Relationship Date

406.549.2006
Fax 406.549.6574


1519 South Reserve Street
Missoula, MT 59801

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefit and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examination or tests conducted will be carefully performed.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joints, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the developement of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal healthy artery. Disease processes, genetic disorders, medications and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissection occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headaches. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated at 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendations to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for my future condition(s) for which I seek chiropractic care from this office.

Patients Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

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Matz Family CHIROPRACTIC

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Missoula, MT 59801

# PATIENT COMPLIANCE ASSURANCE NOTIFICATION

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for use and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that, per our written policy, we respect the privacy, of your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for the purpose of treatment, payment or health care operations. These entitles are most often not required to obtain patients consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your Protected Health Information (PHI). If you choose to give consent in this document, at some future time, you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previous signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and patients without any thought of penalization if they feel an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

Patient's Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

## PREGNANCY

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray for evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ _____ _____

Signature Date

## MINOR CHILD

Consent to evaluate and adjust a minor child.

I, _____, being the parent or legal guardian of _____ have read and fully understand the above informed Consent and hereby grant permission for my child to receive chiropractic care.

Patient Name _____ Date of Birth _____

Parent/Guardian Signature _____ Date _____
Acknowledges Receipt of Notification

Parent/Guardian's Name (Print) _____ Phone# _____