Essential Health

James W. Mattison, Jr, DC

Patient History

Name:_____ Today's Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone (H or C):_____ Work:_____ Email:_____

DOB:_____ Age:_____ Social Security#:_____

Marital Status:_____ How did you find out about our office:_____

Occupation:_____ Employer:_____

Insurance Company:_____ Policy#:_____

Family Medical Doctor:_____ May we contact him/her regarding your care in our office?_____

_____

Date and Nature of Present Complaint:_____

_____

Is this an auto or work related injury?_____ Have you had this condition before?_____

My symptoms began: Gradually_____ Suddenly_____ Not Sure_____

How often during the day or night do you experience these symptoms? 0% 10% 25% 50% 75% 100%

Describe any related accidents or falls to your current condition._____

What aggravates your condition:_____ What helps it?_____

Type of Pain: Sharp___ Dull___ Ache___ Burn___ Throb___ Numb___ Other___

Does it radiate into your: Right arm Left arm Right leg Left leg Other:_____

Please rate your pain (0=no pain 10=unbearable pain) 0—1—2—3—4—5—6—7—8—9—10

480 Memorial Parkway Phillipsburg, New Jersey 08865 Ph: (908) 454-8808 Fax: (908) 998-4762 www.essentialhealthnj.com

Please list all previous treatments for this condition (include doctor or facility name)_____

_____

_____

How has this affected your life?

	Circle one	
Have you missed work?----------	Yes	No
Has the quality of your work been affected?----------	Yes	No
Are you able to do household chores?----------	Yes	No
Has this problem interfered with your social life?----------	Yes	No
Has it interfered with spending time with family and friends?----------	Yes	No
Has it interfered with your recreational activities?(exercise, golf, tennis, etc...)------	Yes	No

Has it affected your life in any other way?_____

_____

Please list all surgeries you have had_____

_____

Please any previous accidents or falls (this includes auto)

Incident _____

When_____ Treatment_____

Incident _____

When_____ Treatment_____

Please list any medication and /or vitamins you take

Type_____ Frequency_____ Doctor_____
Type_____ Frequency_____ Doctor_____
Type_____ Frequency_____ Doctor_____
Type_____ Frequency_____ Doctor_____

Do you have a permanent impairment/disability rating? _____ Date received_____
Location_____ Rating percentage_____ Comments_____

OCCUPATIONAL INFORMATION (please circle all that apply)

Type of work station: Seated Standing Workbench Desk Other_____

Job involves: Lifting Bending Stooping Twisting Turning

Types of shoes: High heels Boots Sneakers Loafers Other_____

Physical work activity: Sedentary Light manual labor Manual labor Heavy manual labor

HEALTH HABITS

Sleep: Hours per night_____ Type of mattress_____
Do you sleep on your: Back_____ Side_____ Stomach_____
Please describe your quality of sleep_____

Exercise: Never_____ 1x/week____ 2-3x/week____ 4-7x/week____ Type_____

Tea/coffee/soda (cups per day) _____ Liquor(drinks per week) _____ Tobacco(packs per day) _____
Special diets_____

Please circle any current or former condition(s)

HIV positive	Gout	Ulcers	Emphysema	Mumps
Appendicitis	Heart Disease	Venereal Infection	Epilepsy	Pleurisy
Anemia	Herpes	Whooping Cough	Hypersensitivity	Chicken Pox
Arteriosclerosis	Influenza	Cold Sores	Asthma	Pneumonia
Arthritis	Low Back Pain	Allergies	Malaria	Polio
Cancer	Small Pox	Diabetes	Measles	Rheumatic Fever
Tuberculosis	Tuberculosis	Diphtheria	Miscarriage	Scarlet Fever
Goiter	Typhoid Fever	Eczema	Multiple Sclerosis	Stroke

Are there any other conditions that the doctor needs to be aware of ?_____

_____

Family Health

Your family history will help us complete your overall health picture. Please list any health conditions for immediate family members (mother, father, grandparents, and siblings)._____

_____

_____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such 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 used to attain it. This will prevent any confusion or disappointment.

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

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations of neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, 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 another health care provider.

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. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustment.

I have read and fully understand the above statements. I acknowledge the information that I have given was completed correctly and to the best of my knowledge. Any questions or concerns regarding the above information have been answered to my complete satisfaction.

_____ _____

Patient Signature **Date**

****

MINOR /CHILD CONSENT FORM

I am the parent, guardian, or personal representative of (print name of child) _____.
There are no court orders now in effect that prohibit me from signing this consent. I do herby request and authorize the doctor and practice staff to perform necessary services for the child named above, including but not limited to X-rays, and treatment which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. If my authorization to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____

Please print name of Guardian **Relationship**

_____ _____

Signature of Guardian **Date**

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 HIPPA 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 affect 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, Jim Mattison, 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 healthcare 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 of Patient Date

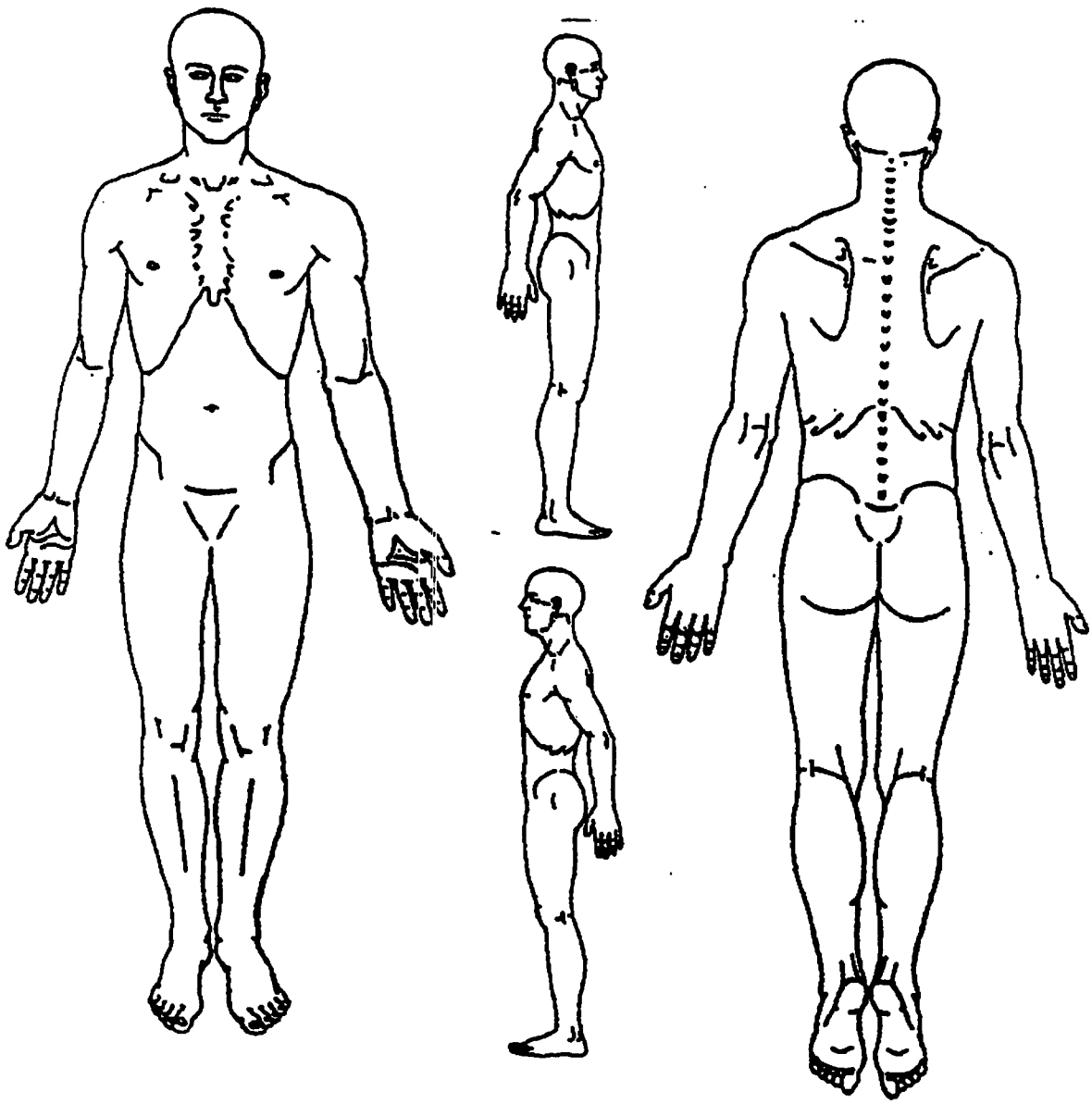
Disability Index (low-back)

Name (please print) _____ Date _____

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas using the appropriate letter(s) listed below. If your pain radiates, draw an arrow from where it starts to where it stops.

A = Ache
B = Burning
N = Numbness
S = Stabbing
P = Pins & Needles
T = Throbbing



Over Please

Oswestry Disability Index (low-back)

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally with no pain.
- ☐ I can look after myself normally with some pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of my personal care.
- ☐ I do not get dressed, I wash with difficulty, and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ¼ of a mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours sleep.
- ☐ Because of pain, I have less than 4 hours sleep.
- ☐ Because of pain, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere, but experience mild pain.
- ☐ Pain is present but I manage journeys of over two hours.
- ☐ I get pain when traveling more then one hour.
- ☐ Pain restricts me to short necessary trips.
- ☐ Pain prevents me from traveling.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

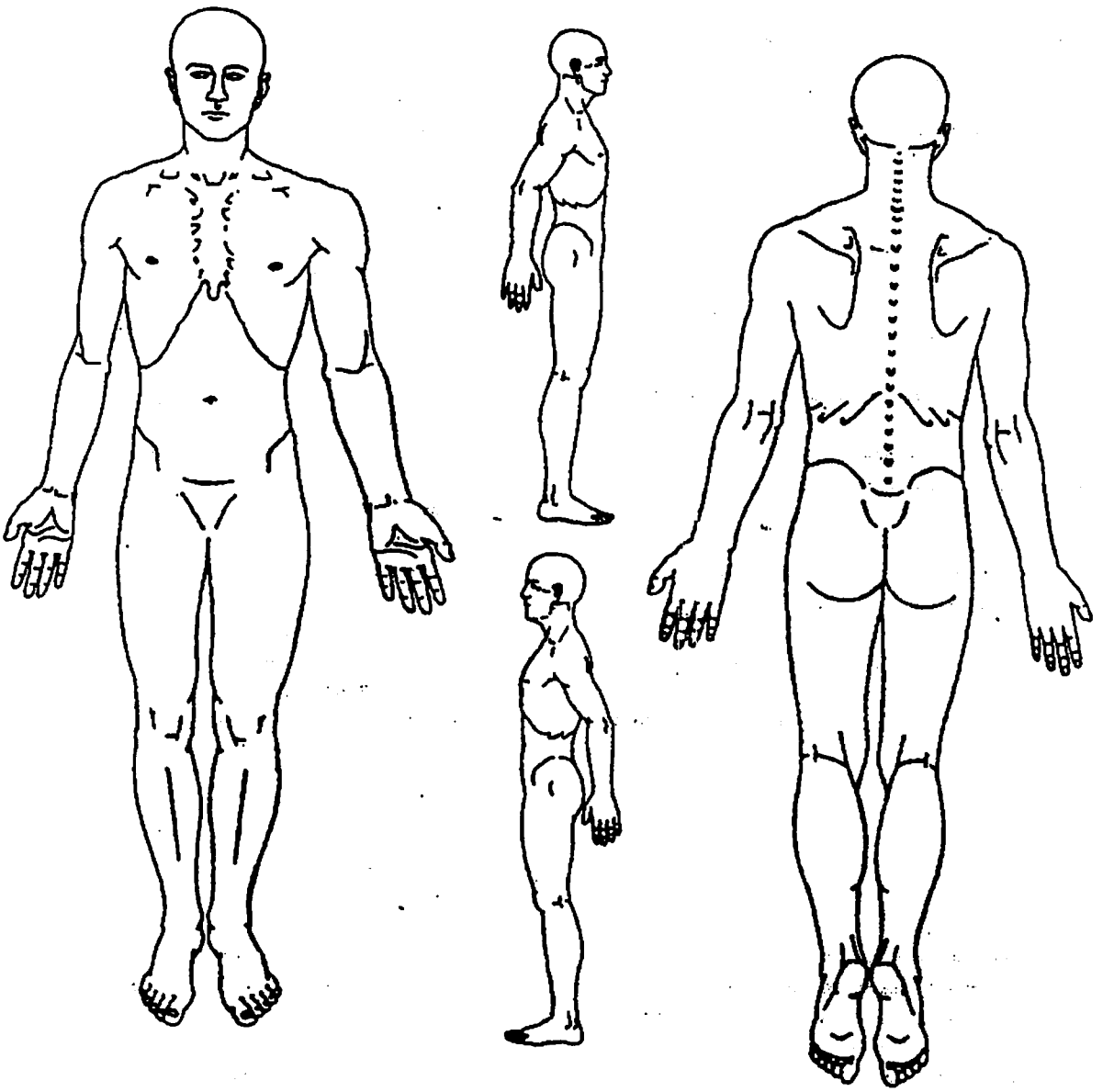
Neck Disability Index

Name (please print) _____ Date _____

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas using the appropriate letter(s) listed below. If your pain radiates, draw an arrow from where it starts to where it stops.

A = Ache
B = Burning
N = Numbness
S = Stabbing
P = Pins & Needles
T = Throbbing



Over Please

Neck Disability Index

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Section 8 – Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I cannot drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour).
- ☐ My sleep is mildly disturbed (1-2 hours).
- ☐ My sleep is moderately disturbed (2-3 hours).
- ☐ My sleep is greatly disturbed (3-5 hours).
- ☐ My sleep is completely disturbed (5-7 hours).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I cannot do any recreation activities at all.

QUADRUPLE VISUAL ANALOGUE SCALE

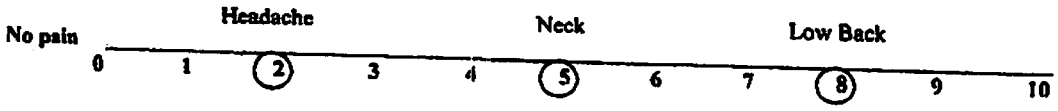
Patient Name _____ Date _____

Please read carefully:

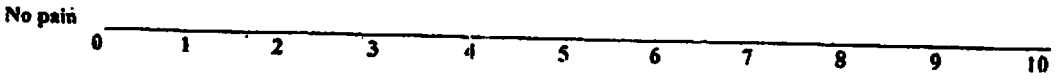
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

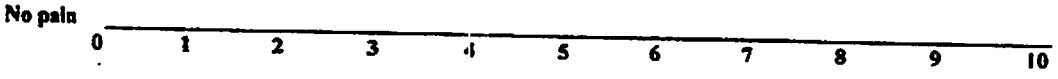
Example:



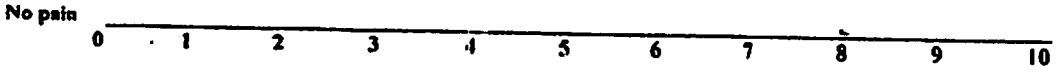
1 – What is your pain RIGHT NOW?



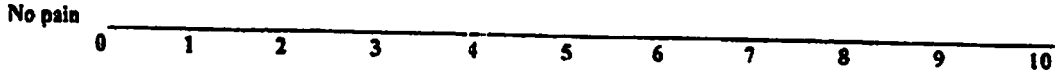
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

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_____
Examiner

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