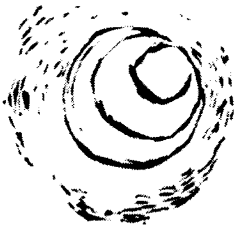

Chiropractic Patient Questionnaire

Date: ______________________
SS#: ______________________

Name ______________________ Date of Birth ______________________
Address ______________________ City/State/Zip ______________________
Email ______________________
Telephone (home) ______________________ (Work) ______________________
Place of Employment ______________________ Occupation ______________________
Married _______ Single _______ Divorced _______ Widow(er) _______ # of Children _______
Spouse's Name ______________________ Place of Employment ______________________
Primary Physician ______________________ Date of last physical ______________________
Dentist ______________________ Date of last visit ______________________
Date of last chiropractic adjustment ______________ Given by Dr. ______________________
In case of emergency, who should we contact?
Name ______________ Phone ______________ Relationship ______________
How did you hear about our office? ______________________

Please provide the following if you would like us to file claims to your insurance policy. Please note that there is $10 fee to file insurance.

Name of insurance company: ______________________
Claim Filing address: ______________________
Insured Person: ______________________
Policy #: ______________________
Group#: ______________________

I agree and acknowledge that when I supply O'Keefe Matz Functional Health with my complete insurance claim filing information and place my signature on this document, I am authorizing O'Keefe Matz Functional Health to submit claims for benefits fo servicees rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and I will be bound by this signature as though I had personally signed the particular claim. I further authorize payment of insurance benefits directly to O'Keefe Matz Functional Health Clinic.

I also understand that I am fully responsible for all charges incurred. There will be an 18% APR charge on all accounts 30 days past due as well as a collection fee if this account is sent to a collection agency or attorney.

Fees are payable at the time services are received. We require 24 hours advance notification of cancellations or changes in appointments, and we reserve the right to charge if sufficient notice is not given.

Patient's Signature ______________________ Date ______________

If under 18 years of age, parent or guardian's signature ______________________

Financial Policy & Agreement

It is the policy of **O'Keefe Matz Chiropractic Clinic** to inform you of charges incurred so that you can plan for payment of your care in advance of your visit.

Please review and initial the following statements:

1. I understand that O'Keefe Matz Chiropractic is not a provider for any major medical insurance company. Auto, Workman's compensation, and Major Medical insurance are accepted with "out of network" coverage. We submit medical insurance forms (**for an extra $10 fee**) and ask that **deductibles and co-insurance payments be made at the time of service. Patients are responsible for any charges incurred that their insurance does not cover. If coverage has not been determined by the first visit – patients are required to pay at the time of service.**

   ____ **initial**

2. I understand that cash patients are to pay for services at the time that they are rendered. Patients are required to contact the front desk if special payment arrangements are necessary. ***We accept payment by cash, check or credit card (Visa, Mastercard, or Discover).***

   ____ **initial**

3. I understand that the discount program, and return policy for the services that I am receiving are the following:

   Supplement Discount Policy (applies only to CURRENT Nutrition patients)
   Current nutrition patients receive a 5% discount on purchases more than $200 and 10% on $300 and up.
   There are no discounts on VSL #3 probiotics and medical food.

   Supplement Return Policy (within 30 days)
   We offer a 100% return on **unopened** supplements, returned within 30 days under $200.
   Return orders over $200 have a 15% restocking fee. There are **NO** returns on probiotics.

   ____ **initial**

4. I understand that I need to provide 24 hours notice for cancellation of your chiropractic appointment. A late cancellation fee of $25 will be assessed and will be the responsibility of the patient and is **NOT BILLABLE** to the insurance company. After two missed or cancelled appointments, you may be billed for the full cost of a chiropractic appointment.

   ____ **initial**

I, the undersigned, have read and understand the above mentioned clinic policies and realize that I am responsible for any and all charges not covered by my insurance. I also understand that there will be an 18% APR charge on all accounts 30 days past due as well as a collection fee if this account is sent to a collection agency or an attorney.

Signature______________________________ **Date**________________

For Office Use Only
Date: ____________
Acct #: ____________

Patient Intake Form

Name: ______________________

Are your present problems due to an injury? ❑Yes ❑No Enter the date of the injury: ____________

Was the injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: ____________

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: ____________

Briefly describe the accident, injury or illness: ____________

List symptoms experienced immediately after the injury: Choose the severity level associated with each symptom

____________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

____________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

____________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

____________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

____________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

List any tests, studies or medications received for this condition:

❑Tests/Studies: ____________

❑Medications: ____________

Where you admitted to the hospital due to this condition: ❑Yes ❑No

If yes, what hospital? ____________ Transported by? ❑Ambulance ❑Police ❑Other: ____________

Date Admitted: ____________ Date Released: ____________ Length of Stay: ____________

List the hospital procedures received: ____________

List symptoms you are experiencing today: Choose the severity level associated with each symptom

____________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

____________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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____________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: ____________ To: ____________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ____________

What type of work do you do? ____________

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No ______________________

____

List any past conditions you may have had: ______________________________

HABITS		EXERCISE	FAMILY HISTORY	Diabetes	Cancer	Back Pain	Other
❑Smoking	Packs/day: _____	❑None					
❑Drinking	Alcohol: (Cups/day): _____	❑Moderate	Mother	❑	❑	❑	❑________
❑Coffee	Cups/Day: _______	❑Daily	Father	❑	❑	❑	❑________
❑Soft Drink	Bottles or Cans/Day: _____	Type: _________	Brother(s)	❑	❑	❑	❑________
❑Water	Cups/Day: _______	_____________	Sister(s)	❑	❑	❑	❑________

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? ❑Yes ❑No
If yes, which ones?: ______________________________

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: ______________________

Do you have allergies? ❑Yes ❑No If yes, please explain: ______________________

Have you ever had any surgeries? ❑Yes ❑No (If yes, please enter the approximate date of surgery.)

DATE		DATE		DATE	
______________	Back Operation	______________	Hernia	______________	Gall Bladder
______________	Female Organs	______________	Thyroid	______________	Stomach

Other ____

Have you ever had X-rays taken? ❑Yes ❑No When? ______________ By Whom? ______________

For what ailments were these X-rays taken? ______________________________

OPERATIONS AND PROCEDURES

Please check the box for each current or past symptom listed.

GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR NOSE/THROAT	RESPIRATORY
❑ Allergy(What) ____ ______________	❑ Belching or Gas	❑ Asthma	❑ Chest Pain
	❑ Colon Trouble	❑ Deafness	❑ Chronic Cough
❑ Bronchitis	❑ Constipation	❑ Earache	❑ Difficulty Breathing
❑ Chills (Constant)	❑ Diarrhea	❑ Ear Discharge	❑ Spitting Blood
❑ Convulsions	❑ Gall Bladder Trouble	❑ Ear Noises	❑ Spitting Phlegm
❑ Dizziness	❑ Hemorrhoids (piles)	❑ Thyroid Problems	
❑ Fainting	❑ Jaundice	❑ Frequent Colds	**GENITO-URINARY**
❑ Fatigue	❑ Liver Trouble	❑ Hay Fever	❑ Bed Wetting
❑ Headache	❑ Nausea	❑ Nasal Obstruction	❑ Blood in Urine

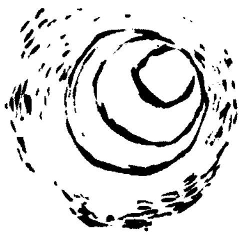
GENERAL SYMPTOMS	GASTRO-INTESTINAL	EYE/EAR NOSE/THROAT	GENITO-URINARY
❑ Loss of Sleep	❑ Stomach Pain	❑ Nose Bleeds	❑ Frequent Urination
❑ Loss of Weight	❑ Vomiting	❑ Pain in Eyes	❑ Inability to Control Urine
❑ Nervousness	❑ Vomiting Blood	❑ Poor Vision	❑ Kidney Infection
❑ Night Sweats	❑ Heart Burn	❑ Blurred Vision	❑ Kidney Stones
❑ Numbness or Pain in arms/legs/hands	❑ Bloody Stools	❑ Sinusitis	❑ Painful Urination
❑ Wheezing	❑ Acid Reflux	❑ Sore Throats	❑ Prostate Trouble
	❑ Irritable Bowel	❑ Tonsillitis	
MUSCLES & JOINTS	**CARDIO-VASCULAR**	**SKIN OR ALLERGIES**	**FOR FEMALES ONLY**
❑ Backache	❑ High Blood Pressure	❑ Bruising Easily	❑ Cramps
❑ Foot Trouble	❑ Low Blood Pressure	❑ Dryness	❑ Hot Flashes
❑ Hernia	❑ Chest Pain	❑ Eczema	❑ Irregular Cycle
❑ Pain Between Shoulders	❑ Heart Trouble	❑ Hives or Allergy	❑ Painful Periods
❑ Painful Tail Bone	❑ Poor Circulation	❑ Itching	❑ Vaginal Discharge
❑ Stiff Neck	❑ Rapid Heart	❑ Sensitive Skin	❑ Pregnant Now?
❑ Spinal Curvature	❑ Slow Heart	❑ Skin Eruptions	________ Last Pap Date
❑ Swollen Joints	❑ Strokes		________ Last Menstrual Cycle
❑ Tremors	❑ Swelling Ankles		
❑ Twitching	❑ Varicose Veins		

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: ______________________________ **Date:** ____________



O'Keefe Matz
functional health clinic

Chiropractic Symptom Analysis

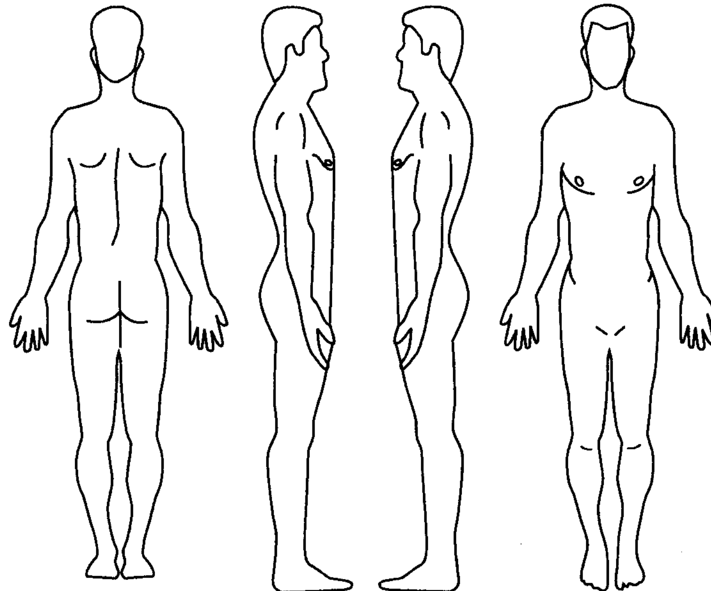
Name: ______________________________

Date: ______________________________

What are your primary complaints related to your pain/problem? ______________________________

____

____



Describe the pain/sensation by circling any of the following words listed below.

prickling	soreness	abrupt onset
burning	tenderness	slow & progressive
sharp	tickling	localized
dull	superficial	generalized
throbbing	deep	short duration
knifing	immobilizing	long duration
aching	diffused	constant
boring	numbing	intermittent
crushing	itching	occasional
cramping	piercing	shooting
stinging	overwhelming	nauseating
inflamed	sensitive	intense

Is there any radiation of pain into other areas? ______________________________

If so - describe ______________________________

Name: __________ Date:__________

Estimate the number of hours of pain or difficulty:
Per day_________Per week _________Per month ________

Is the pain less in the morning or at the end of the day?

____

Circle the activities which aggravate the condition or make the pain worse. Space is provided to add activities not listed.

walking	lack of sleep	work duties:
sitting	weather	____________________
standing	writing	____________________
laying down	bending	____________________
exercising	driving a car	sport activities:
lifting	sneezing/coughing	____________________
____________________	____________________	____________________
____________________	____________________	____________________

What decreases the pain? (ie: inactivity, medication, ice, etc)

____

____

When did the PRESENT problems begin? ______________________________________

____

What do you think is the cause of the pain/problem? (accident, disease, activity, etc.)

____

What were the first signs of the pain/problem?

____

Has the pain/problem increased, decreased or changed since it's onset - if so how?

____

What treatments/care have you received for this pain/problem?

Doctors / hospitals / medications: Dates:

____

____

____

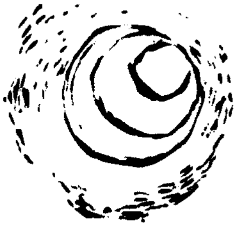
____

What diagnosis have you received for your pain/problem?

____

Does your pain/problem interfere with your ability to (circle):

sleep	drive	walk
exercise	dance	leisure/hobbies:
work activities:	house chores:	________________
________________	________________	________________
________________	________________	________________



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Health History

Patient Name: ______________________________

Date: ______________________________

Date of birth: ______________________________

Please check any symptoms or conditions that have applied to you in the past or apply to you now.

Condition	Past / Present	Condition	Past / Present
Allergies	____ / ____	Chronic cough	____ / ____
Alcoholism	____ / ____	Hoarseness	____ / ____
Anemia	____ / ____	Difficulty breathing	____ / ____
Arthritis	____ / ____	Chest pain	____ / ____
Cancer/tumor	____ / ____	Coughing up phlegm	____ / ____
Chickenpox	____ / ____	Pain over heart	____ / ____
Colitis	____ / ____	Rapid heartbeat	____ / ____
Diabetes	____ / ____	High blood pressure	____ / ____
Eilepsy	____ / ____	Low blood pressure	____ / ____
Influenza	____ / ____	Varicose veins	____ / ____
Kidney problems	____ / ____	Poor appetite	____ / ____
Liver problems	____ / ____	Excessive hunger	____ / ____
Malaria	____ / ____	Excessive gas	____ / ____
Measles	____ / ____	Constipation	____ / ____
Hepatitis	____ / ____	Diarrhea	____ / ____
Mental Illness	____ / ____	Hemorrhoids	____ / ____
Pneumonia	____ / ____	Painful joints	____ / ____
Polio	____ / ____	Venereal disease	____ / ____
Rheumatic Fever	____ / ____	Thyroid condition	____ / ____
Substance abuse	____ / ____	Tuberculosis	____ / ____
Tremors	____ / ____	Tonsillitis	____ / ____
Weight gain/loss	____ / ____	Typhoid fever	____ / ____
Eye strain	____ / ____	Ulcers	____ / ____
Deafness	____ / ____	Convulsions	____ / ____
Ear discharge	____ / ____	Dental problems	____ / ____
Colds nosebleeds	____ / ____	Dizziness	____ / ____
Sinusitis	____ / ____	Fainting	____ / ____
Anxiety	____ / ____	Fever	____ / ____
Depression	____ / ____	Bedwetting	____ / ____
Headaches	____ / ____	Blood in urine	____ / ____
Paralysis	____ / ____	Painful urination	____ / ____
Skin problems	____ / ____	Pus in urine	____ / ____
Swats	____ / ____	Food problems	____ / ____
Stomach pain	____ / ____	Nausea	____ / ____
AIDS/HIV positive	____ / ____	Abnormal stool	____ / ____
Loss of bladder control	____ / ____	Gall bladder problems	____ / ____
____________	____ / ____	____________	____ / ____

Name:____________ Date:________

WOMEN ONLY:

Vaginal discharge	____ / ____	Irreg. menstrual flow	____ / ____
Profuse flow	____ / ____	Premenstrual symptoms	____ / ____
Menstrual pain	____ / ____	Menopausal symptoms	____ / ____
Breast soreness	____ / ____	Lumps in breast	____ / ____

Method of birth control ____________________

Number of successful pregnancies ____________________

Number of miscarriages____________________

Number of abortions____________________

What surgeries have you had? ____________________

What accidents or injuries have you had? ____________________

FAMILY HISTORY:

Mother's age ____ Health problems____________________

Father's age ____ Health problems ____________________

Please detail any health problems of your siblings ____________________

Has anyone in your family ever had:

	yes / no	Comments
Allergies	____ / ____	____________
Arthritis	____ / ____	____________
Cancer	____ / ____	____________
Diabetes	____ / ____	____________
Heart Disease	____ / ____	____________

Other ____________________

O'Keefe Matz Chiropractic Clinic
1053 Ashland Ave., St. Paul, MN 55104
(651) 292-8072 – Phone / (651) 292-8722 - Fax

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of this office's Notice of Privacy Practices. I understand that 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 among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

____

{Please Print Name}

____

{Signature}

____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)____

____

Staff Signature Date