Ralphael Mattei, D.C.

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PLEASE PRINT ALL INFORMATION CLEARLY

Today's Date: _____ Referred by: _____

D.O.B: _____ Age: _____ Height:_____Weight:_____ ☐ Male ☐ Female ☐ Transgender ☐ Transsexual

Name: _____

Contact number: _____ Home ☐ Mobile ☐ Work ☐

Email: _____

Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Martial Status: ☐ S ☐ M ☐ D ☐ W Children: ☐ Y ☐ N Number of Children: _____ **Are you pregnant?** ☐ Y ☐ N

Emergency Contact Person: _____ **Number:** _____

Why are you here today / Chief Complaint: _____

_____

Do you have other health concerns? ☐ Y ☐ N

If yes, list the top 3 in order of importance:

1. _____ 2. _____ 3. _____

Stress: Please rate your overall current stress level (1 to 10, 1 = very low and 10 = extremely high) _____ / 10

List the top 3 reasons for your stress at this time:

1. _____ 2. _____ 3. _____

Check the level of pain and interference you are experiencing:

No Pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities?

No Interference ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Unable to carry on any activities**

Have you lost any feeling or strength in any part of your body? ☐ Y ☐ N

Where in the body?

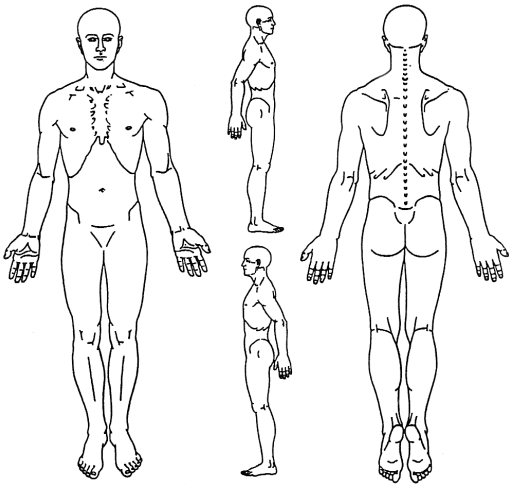
_____

Does the pain spread to other parts of the body? ☐ Y ☐ N

Where in the body?

_____

Please mark the area of major complaint(s), on the diagrams.



Is the Pain:

☐ continuous ☐ intermittent

☐ sharp ☐ dull ☐ achy ☐ throbbing

☐ cramping ☐ severe ☐ burning

☐ constricting ☐ crushing

☐ pressing

PRINT / LIST **ALL** surgeries .

Surgery	Year preformed

PRINT /LIST **ALL** past medical history (diabetes, cancer, illnesses, etc..)

Diagnosed Condition	Year Diagnosed

PRINT / LIST **ALL** supplements, herbal remedies, etc.that you are taking **now**:

Name	Frequency	For what condition / symptoms

PRINT / LIST **ALL** medications that you are taking **now**:

Name	Frequency	Treating

Agreement of Policies and Informed Consent for Treatment

1) PAYMENT IS REQUIRED AT THE TIME SERVICES ARE PROVIDED:

Payment for appointments can be made with cash, checks, and credit cards. If you are experiencing **financial hardship** and require special arrangements, please notify prior to receiving care.

2) THIS OFFICE MAINTAINS A 24 - HOUR CANCELLATION POLICY:

Arrive on time for your appointments. If you arrive late, the time missed may be deducted from your appointment.

Rescheduling / Last minute cancellations / Not showing up for your appointment: If you need to reschedule an appointment, I ask that you give at least 48 hours notice and if you do not notify the office at least 24 hours in advance, you are responsible for paying in full for your appointment.

3) I release Dr. Mattei from HIPAA compliance and give him permission to share information about me with his staff and others whenever he feels it is necessary and appropriate to support my care, to work with others who may be involved with my care, to increase my likelihood of being reimbursed, to protect his interest, for office purposes, or when required to do so by law.

I hereby request and consent to treatment and procedures from Dr. Ralphael Mattei, which may include, but not limited to structural, biochemical, and functional neurological assessments and / or physiotherapy, diagnostic imaging, and laboratory analysis.

I understand that there are risks to chiropractic adjustments including, but not limited to, sprains, strains, fractures, disc injuries, strokes, and dislocations. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor's judgment during the course of my care and request that he does what he feels at the time is in my best interest, based on the facts then known. It is my understanding that the techniques practiced in this office are among the gentlest in the chiropractic profession, with a correspondingly lower likelihood of injury.

I have read or have had the above policies and consent agreement read to me. Also, I have discussed the treatment with my doctor and have had all my questions answered.

By my signature, I understand and agree to the above policies and consent agreement and request treatment from Dr. Mattei. I intend this consent form to cover any care, which I receive in or through Dr. Mattei's office now and in the future.

_____ _____ _____

PRINT Name (Patient's) Patient's Signature Today's Date

_____ _____

PRINT Guardian's Name if Patient is under 18 years old Guardian's Signature