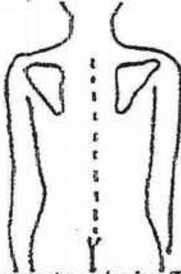
MATTHEW E. SHEEHAN, DC
Tax ID # 93-0944493
Medicare # 0000QGFMV • Medicaid # 051990

MEDFORD FAMILY CHIROPRACTIC CTR
328 S Central, Ste 101, Medford, OR 97501
Tel (541) 773-1321 • Fax (541) 857-4011

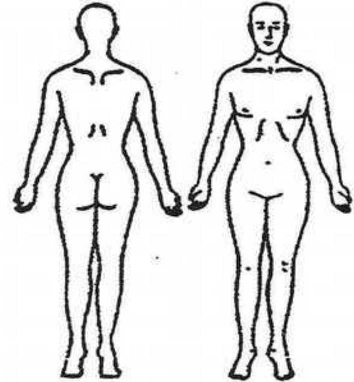
Patient Health History

Name ______________________________ Date: ________________

ease indicate where your pain is. Indicate the appropriate location using the symbol
at best describes the discomfort you are presently experiencing. Demonstrate traveling symptoms
th arrows.



SHARP AND STABBING = *
DULL AND ACHY = V
PINS AND NEEDLES = O
NUMBNESS = /



Describe your symptoms/pain. (Where do you hurt?)
____

Type of pain. (Circle one or more)

A. Dull ache   C. Burning   E. Radiating   G. Other
B. Sharp shooting   D. Deep   F. Numbness/tingling   H. Describe ________

Please list any associated symptoms. (i.e. leg pain, fatigue, irritability, headache, difficulty sleeping, etc.)________

Please circle the intensity that best describes your pain.

At present:	Mild	Moderate	Severe	Excruciating
Worst it gets:	Mild	Moderate	Severe	Excruciating
Best it gets:	Mild	Moderate	Severe	Excruciating

Did the problem start: A. Gradually___ or B. Suddenly___? Describe when and how it began. Tell about any injury.
____

Is the problem: A. Constant___ B. Off and On___ C. Worse different times of the day___?

Compared to when it started, is your pain: A. Better___ B. Worse___ C. The same___?

What makes the pain better? A. Heat B. Ice C. Medication D. Lying down E. Moving F. Other________

What makes it worse? A. Coughing B. Sneezing C. Sitting D. Getting up from sitting E. Twisting F. Other________

). Have you had problems in this area before?______ Describe them, and how long you've had them.________

1. List any medication(s) you are now taking:________
2. Please list any pertinent surgeries or hospitalizaion:________
3. Do you feel your work or life-style contributes to this problem?______ What about your diet?______
4. Are there any secondary problems you want to talk to the Doctor about?________

(If additional space is required, please continue on back)

Matthew E. Sheehan, DC
Medford Family Chiropractic
328 S. Central, Suite 101, Medford, OR 97501
(541) 773-1321

Patient Registration

Thank you for choosing our practice for your healthcare needs. Please complete the following form. If you have any questions, please feel free to ask for assistance. We will be happy to help.

Name:____
Last First , Middle

Address:______________________________State:______Zip:__________

Mailing Address (if different):______________________Email:______________

Cell Phone #:____________________Home/Alternate Phone #:______________

Age:_____Date of Birth:____________Gender: M F Social Security #:______________

Employer:____________________________Work Phone #:______________

Spouse's or Parent's Name:______________________________________

Spouse's or Parent's Employer:______________________________________

Who should we notify in case of emergency?______________________________

We can we thank for referring you to us?

Friend:________________Doctor:________________Other:______________

Responsible Party:

Name of person responsible for this account:______________________________

Relationship to patient:______________________Phone #:______________

Address:____

Employer:______________________________Work Phone #:______________

Insurance Information:

Name of Insured:__________________________Relationship to patient:____________

Date of Birth:____________Insurance ID#:________________Group #:__________

Insurance Company:__________________________Phone #:______________

Address:____

The above is correct to the best of my knowledge. I understand that any error in the above information may result in delays of payment. I understand that my insurance may pay less than actual charges and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____ Date:______________
Signature of Patient (or Parent of Minor)

MATTHEW E. SHEEHAN,D.C.
x I.D. #93-0944493
edicare #0000QGFMV ■ Medicaid #051990

MEDFORD FAMILY CHIROPRACTIC CENTER
832 E. MAIN STREET ■ SUITE 5
MEDFORD, OR 97504 ■ (541) 773-1321

Patient Health History

Surgeries: (Give year or age)

[ ] Tonsils [ ] Appendix [ ] Hysterectomy [ ] Gall Bladder [ ] Kidney
[ ] Heart [ ] Hernia [ ] Spine [ ] Prostate [ ] Cyst
[ ] Cancer [ ] Other__________

Birth defects/deformities:__________

Traumas: (Give date and body part involved)

Vehicle Accidents__________

Work Injuries__________

Sports Injuries__________

Slip and Fall Injuries__________

Lifting Injuries__________

Concussions__________

Fractures__________

Dislocations__________

Other Injuries__________

Have you, or anyone in your family ever had any of the following illnesses? **(Blood relatives only, please)**
(Put an **S** for Self, **M** for Mother, **F** for Father, **C** for Children, **B** for Brother, **SS** for Sister, **MM** for Mother's Mother, etc.)

[ ] Measles
[ ] Mumps
[ ] Chicken Pox
[ ] Diptheria
[ ] Whooping Cough
[ ] Rheumatic Fever
[ ] Scarlet Fever
[ ] Polio
[ ] Obesity
[ ] Multiple Sclerosis
[ ] Epilepsy
[ ] Frequent Colds
[ ] Hay Fever
[ ] Asthma
[ ] Bronchitis
[ ] Pneumonia
[ ] T.B.
[ ] Emphysema
[ ] Allergies
[ ] Alzheimer's Disease
[ ] Mononucleosis
[ ] VD
[ ] Herpes II
[ ] Hepatitis
[ ] Hypoglycemia
[ ] Diabetes
[ ] Hypothyroid
[ ] Ulcers
[ ] Lupus
[ ] Crohn's Disease
[ ] Colitis
[ ] Hemorrhoids
[ ] Gall Stones
[ ] Kidney Stones
[ ] High Blood Pressure
[ ] Heart Attack/Disease
[ ] Stroke
[ ] Paralysis
[ ] Addictions
[ ] Scleroderma
[ ] Gout
[ ] Osteoarthritis
[ ] Rheumatoid Arthritis
[ ] Cancer
[ ] Cataracts
[ ] Glaucoma
[ ] Irritable Bowel Syndrome
[ ] Ankylosing Spondylitis
[ ] Other__________

Family History:

Mother: Living____ Health Status__________ D ____ Cause__________

Father: Living____ Health Status__________ D ____ Cause__________

Sisters: ____ Living____ Health Status__________ D ____ Cause__________

Brothers:____ Living____ Health Status__________ D ____ Cause__________

#Children:____ Living____ Health Status__________ D ____ Cause__________

Is there a history of Cancer or Diabetes in your immediate family?__________

Is there a history of your illness or condition in your family?__________

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APPOINTMENT POLICY

24 hours' notice is required for appointment cancellation (unless there are extenuating circumstances). Appointments missed without prior notification must be paid for at the time of the next visit.

I have read and understand and agree to the above statement.

____

Signature Date

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Welcome to our office! We appreciate the trust you have placed in us to achieve and safeguard your health and well being. We will do everything we can to assure that trust.

As with any business, your payment for our services is what keeps our door open. You are ultimately responsible for all fees relating to your care. Your health insurance policy is your agreement with your health insurance carrier and is your responsibility. Please speak to us before receiving care if you have any questions about payment or your bill. Below is our financial policy.

FINANCIAL POLICY

We require payment in full at the time of your visit unless:

1. You are on a managed care plan for which we are a preferred provider and this has been verified. You will then only be required to pay your co-pay at the time of your visit.

2. You have other health insurance and we can verify what your portion should be.

3. You have been in a motor vehicle accident and we are going to bill your automobile insurance under your Personal Injury Protection.

4. We are treating you for a work-related injury.

5. You have made specific payment arrangements with our office.

Note: All supplements and supplies must be paid for at the time of service unless covered by insurance.

I have read and understand the above information.

____

Signature Date

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Patient Health History

Past Symptoms - Please Check [ ] Current Symptoms - Please Check ( )

Musculo-Skeletal System
[ ] ( ) Neck Pain/Stiffness/Numbness
[ ] ( ) Pain between Shoulder Blades
[ ] ( ) Low Back Pain/Stiffness/Numbness
[ ] ( ) "Sciatica" (Leg Pain)
[ ] ( ) Pain/Numbness/Weakness - Hip/Leg/Foot
[ ] ( ) Pain/Numbness/Weakness - Shoulder/Arm/Hand
[ ] ( ) Pain/Stiffness/Swelling of Joints/Arthritis
[ ] ( ) Torn Muscles/Ligaments

Nervous System
[ ] ( ) Tremors
[ ] ( ) Muscle Atrophy (Shrinking)
[ ] ( ) Muscle Jerking
[ ] ( ) Fainting
[ ] ( ) Dizziness
[ ] ( ) Paralysis//Weakness
[ ] ( ) Convulsions (Seizures)
[ ] ( ) Headaches
[ ] ( ) Numbness

Eyes
[ ] ( ) Vision Problems
[ ] ( ) Cataracts
[ ] ( ) Glaucoma

Ears
[ ] ( ) Loss of Hearing
[ ] ( ) Ear Infections
[ ] ( ) Ringing in the Ears

Sinus/Nose
[ ] ( ) Post Nasal Drip
[ ] ( ) Chronic Nasal Congestion
[ ] ( ) Recurrent Nose Bleeds

Throat/Mouth
[ ] ( ) Excessive Tooth Decay
[ ] ( ) Missing Teeth/Dentures
[ ] ( ) Braces on your Teeth
[ ] ( ) Clicking/Locking Jaw
[ ] ( ) Grinding Teeth
[ ] ( ) Jaw Pain

Skin
[ ] ( ) Hives
[ ] ( ) Acne/Boils
[ ] ( ) Sebaceous Cysts (at the base of hair follicle)
[ ] ( ) Bruise Easily
[ ] ( ) Slow Wound Healing
[ ] ( ) Dermatitis/Eczema/Seborrhea/Psoriasis/Other

Nails
[ ] ( ) Ridged/Split/Thickened

Energy Level: Average Hours of Sleep______
[ ] ( ) Insomnia
[ ] ( ) Chronic Fatigue
Describe your General Energy Level:______________________________

Symptoms - (Have you ever had or do you now have)

Circulatory System
[ ] ( ) Cold Hands/Feet
[ ] ( ) Phlebitis
[ ] ( ) Hardening of the Arteries

Heart/Lungs
[ ] ( ) Chest Pains
[ ] ( ) Palpitations/Irregular Heartbeat
[ ] ( ) Difficult Breathing
[ ] ( ) Persistent Cough

Digestive System
[ ] ( ) Heartburn
[ ] ( ) Excessive Gas/Bloating
[ ] ( ) Parasites
[ ] ( ) Blood in Stools
[ ] ( ) Chronic Constipation/Recent
[ ] ( ) Chronic Diarrhea
[ ] ( ) Excessive Weight Loss
[ ] ( ) Nausea, Vomiting, Abdominal Pain

Urinary System
[ ] ( ) Difficult/Painful/Frequent Urination
[ ] ( ) Blood or Puss in Urine
[ ] ( ) Loss of Bladder Control

Female
[ ] ( ) Tipped Uterus
[ ] ( ) Endometriosis
[ ] ( ) Intense Menstrual Cramps
[ ] ( ) Irregular Menstrual Cycle
[ ] ( ) Breast Lumps/Pain
[ ] ( ) Vaginal Discharge/Infections
[ ] ( ) Menopausal Problems
[ ] ( ) Births Live______ Still______
[ ] ( ) Miscarriages How Many?______
[ ] ( ) Surgical Abortions
[ ] ( ) Are you now pregnant?
Number of Days in Menstrual Cycle______
Number of Days in Menstrual Flow______
Is Flow: Heavy______ Light______ Normal___

Male
[ ] ( ) Prostate Problems
[ ] ( ) Discharge/Sores
[ ] ( ) Impotence/Sterility

General
[ ] ( ) Excessively Worried
[ ] ( ) Irritable
[ ] ( ) Forgetful
[ ] ( ) Depressed
[ ] ( ) Fearful
[ ] ( ) Confused

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio-therapy, physical medicine, physical therapy procedures, etc. by my doctor of chiropractic named above, and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications which may arise during chiropractic treatments. Those complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, Homers syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels, at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel, the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this healthcare office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE

____
Print Name of Patient

____
Signature of Patient **Date**

____
Signature of Representative (if patient is a minor or handicapped) **Date**

____
Witness to Patient's Signature **Date**

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PRIVACY POLICY STATEMENT

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship.
This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and heal information in several ways.
- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship, we will likely use and disclose health information by submitting the authorization in writing. Disclosures will be made to any personal representative you choose to allow to have your protected health information.

Marketing: This office will not use your health information for marketing communication without your written authorization. This office may send birthday cards, newsletters and appointment reminders, by telephone, correspondence, post cards or letters.

Disclosure: This office may use or disclose your Protected Health Information when required by law.

Patient Rights:
1. Upon written request, you have the right to access, review or receive copies of your healthcare records.
2. Upon written request, you have the right to receive a list of your healthcare information that this office has disclosed.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. Upon written request, you have the right to amend your Protected Health Information.
5. You have the right to receive all notices in writing.

If you have any questions, complaints or want more information, contact this office.

Contact: Matthew E. Sheehan, D.C.
Telephone: (541) 773-1321
Fax: (541) 857-4011
Address: 328 S. Central, Suite 101, Medford, OR 97501

You may submit a written complaint to the U.S. Department of Health and Human Services.

I, ______________________________, have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office. A copy of the Privacy Policies can be obtained upon request.

____

Patient Signature **Date**