ADVANCED METHODS HEALTHCARE

Natural answers to your healthcare needs.

Dr. Clifford Mattson NMD, DC, PhC
Phone: 951-205-3206
Toll Free: 800-933-2395
17924 Krameria Ave., Riverside, CA 92504

NEW PATIENT INFORMATION

PATIENT NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME):					
SEX: □ MALE □ FEMALE	AGE:	DATE OF BIRTH (MM/DD/YY):	WEIGHT:	HEIGHT:	
SOCIAL SECURITY NUMBER:		DRIVER'S LICENSE NUMBER:		DL STATE:	
ADDRESS:		CITY:	STATE:	ZIP:	
HOME PHONE:	WORK PHONE:	CELL PHONE:	EMAIL:		
YOU HAVE INSURANCE?: □ YES □ NO	INSURANCE NAME:				
MARITAL STATUS: □ S □ M □ W □ D	SPOUSE'S NAME:				
NAME OF CHILD 1:				AGE:	
NAME OF CHILD 2:				AGE:	
NAME OF CHILD 3:				AGE:	
NAME OF CHILD 4:				AGE:	
OCCUPATION (SPECIFIC JOB TITLE):		BUSINESS/EMPLOYER:			
BUSINESS/EMPLOYER'S ADDRESS:					
NEAREST RELATIVE:	ADDRESS:		PHONE:		
I WAS REFERRED TO THIS OFFICE BY:					
INJURED FROM WORK?: □ YES □ NO	TYPE OF INJURY OR COMPLAINT?:				
CURRENT MEDICATIONS:					
□ INSULIN	□ ASPIRIN/SIMILAR	□ BLOOD PRESSURE	□ OTHERS		
□ TRANQUILIZERS	□ HORMONES	□ PAIN KILLERS/MUSCLE RELAXANTS			
SPECIFIC DRUG OR SUBSTANCE:					
ANY VITAMINS?:	ANY HERBS?:	HOMEOPATHIC?:			

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below including those working at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks of treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for any present condition or for any future condition(s) for which I seek treatment.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, this clinic may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable for all or any portion of the clinic's charge including but not limited to insurance companies, health care service plans or worker's compensation carriers.

FINANCIAL AGREEMENT: The undersigned agrees that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney's fee and collection expense. All delinquent accounts shall bear interest at the legal rate.

AGGREMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the clinic any insurance benefits otherwise payable to or on behalf of the undersigned for treatment rendered at a rate not to be exceed the clinic's regular charges. It is agreed that payment to the clinic, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the intent of such payment. It is understood by the undersigned that he/she is responsible for any charges not covered by this assignment.

PATIENT'S SIGNATURE:____DATE:__________________

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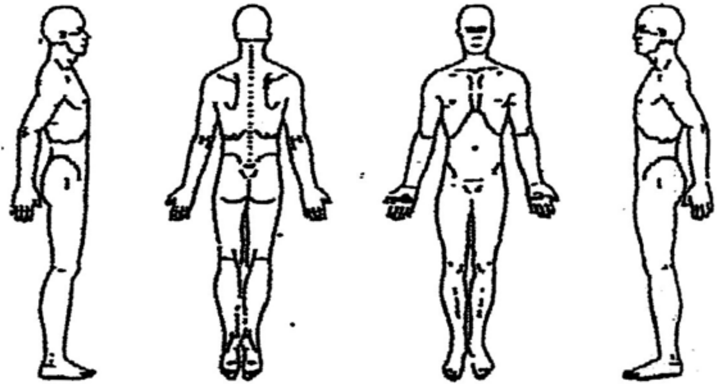
Dear Patient, welcome to our clinic, this form is designed to help us get to the cause of your current health problem as quickly as possible. The more detailed and accurate you are, the better care we can provide. Your overall health is just as important to us as your current major complaints. No symptom is insignificant. The more you tell us, the more we will be able to help you achieve your health goal.

CURRENT HEALTH CONDITIONS
Please fill out one section for each major complaints, starting with the one you feel is most significant, indicate on drawings where your pain is located.

Name:____Date:___________________

MAJOR COMPLAINT:______________________________ Date of onset:____________________ □ Sudden □ Gradual
How bad is your pain or ache?
Please circle number: 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain
Describe your pain or complaint:
□Dull □Sharp □Ache □Stabbing
□Deep □Superficial □Spasm □Numbness
□Tingling □Burning □Other
Radiation: Does the pain go to other parts of the body?
□Yes □No Where?_________________
Frequency:□Occasional □Intermittent □Constant
Duration: How long does the pain last?____________________
What makes the pain worse?
□Standing □Sitting □Bending □Twisting
□Walking □Lifting □Sleeping □Heat
□Cold □Stooping □Sex □Other
What makes the pain better?
□Sitting □Standing □Rest □Heat □Cold
□Aspiring/medication □Other_______________
Other problems related to your main complaint:____
What treatment have you received for this condition?____



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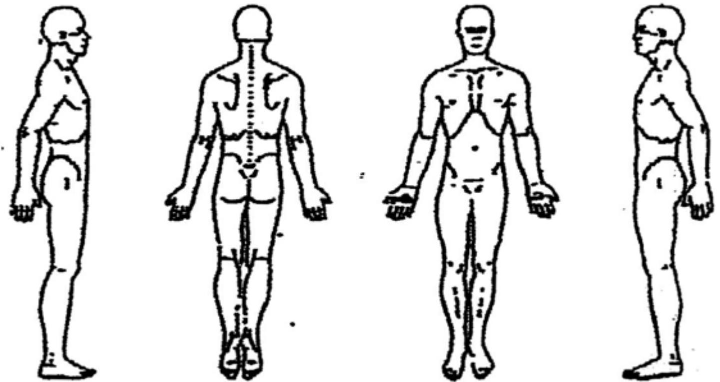

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