



Matthew Eisen, D.C.

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 www.drmattdcares.com

**Welcome** to Eisen Family Chiropractic - where your health always comes first. If you are reading this, you have been fortunate enough to qualify for a **consultation** with one of our doctors. This however does not mean that your case has been accepted. Your consultation today will help determine if you are a legitimate candidate for our successful program of care or if your case will need to be referred out to another physician or specialist.

*The purpose of our office is to restore and maintain the health of our patients through natural chiropractic methods.*

*Please complete this confidential health questionnaire fully and accurately. The more we know about the overall picture of your health, the better we will be able to help you.*

*Doctors of Chiropractic are trained to detect and correct vertebral subluxations. Please respond to this questionnaire thoroughly, to help us determine potential causes and effects of subluxation in your case.*

*If you have any questions, please do not hesitate to ask one of our chiropractic assistants for guidance.*

**Experience with Chiropractic Care**

Who referred you to this office? \_\_\_\_\_

Have you ever been adjusted by another Chiropractor? Yes No

Reasons for those visits? \_\_\_\_\_

Were X-Rays taken? Yes No

Perform spinal rehab exercises? Yes No

Did your family receive chiropractic? Yes No

Chiropractor's Name \_\_\_\_\_

Approximate Date of Last Visit \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_ Sex M F

Today's Date \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Best Place To Reach You (circle one) Home / Cell / Work / Email  
 May we leave a message for you? Yes No

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Length of Employment \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed

Name of Spouse/Significant Other \_\_\_\_\_

Spouses Occupation \_\_\_\_\_ Employer \_\_\_\_\_

*Most new patients are referred from friends & family - How did you hear about our office?* \_\_\_\_\_

*Insurance Information - Please give the front desk your insurance card and drivers license.* Ins. Company \_\_\_\_\_

Policy # \_\_\_\_\_ Name of Primary \_\_\_\_\_

DL# \_\_\_\_\_ State \_\_\_\_\_ SSN# \_\_\_\_\_

**Goals for my Care - Check One**

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for the correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when making recommendations for care. Please check the type of care desired so that we may be guided by your wishes whenever possible:

- Auto Accident, Personal Injury or Workers Compensation
- Relief Care – symptomatic relief of pain or discomfort.
- Corrective Care – correcting and relieving the cause of the problem as well as the symptoms.
- Comprehensive Care – bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic adjustments.
- I want the Doctor to select the care appropriate to my health status.

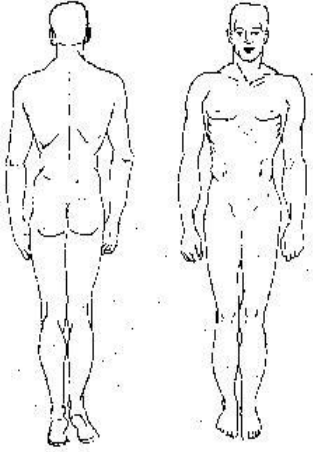
\_\_\_\_\_  
 (Signature)

\_\_\_\_\_  
 (Date)

**What Brings You to Our Office Today?** (Please fill everything out completely • N/A = Not Applicable)

**PLEASE CIRCLE** the areas that bother you and **MARK** the areas on the diagram with the following letters to describe your symptoms:

**R = Radiating B = Burning A = Aching**  
**N = Numbness S = Sharp/ Stabbing**  
**T= Tingling D = Dull**



• **Number One Complaint:** \_\_\_\_\_

- Date when symptom first appeared \_\_\_\_\_
- Was the Onset: Gradual Sudden Progressive over Time

• What makes it feel better? \_\_\_\_\_

• What makes it feel worse? \_\_\_\_\_

- Type of Pain: Sharp Dull Ache Burn Throb
- Do you experience Numbness or Tingling? Yes No
- Pain radiate into your: Upper Arm Lower Arm Upper Leg Lower Leg
- How often do you experience this? 100% 75% 50% 25% 10%
- Pain Intensity: No Pain Mild Pain Moderate Pain Unbearable Pain
- Have you ever been to another doctor for this problem? Yes No
- Doctor \_\_\_\_\_ DC MD Other \_\_\_\_\_ Date \_\_\_\_\_

• What were the results? \_\_\_\_\_

• **Second Complaint:** \_\_\_\_\_

- Date when symptom first appeared \_\_\_\_\_ • Was the Onset: Gradual Sudden Progressive over Time

• What makes it feel better? \_\_\_\_\_

• What makes it feel worse? \_\_\_\_\_

- Type of Pain: Sharp Dull Ache Burn Throb • Do you experience Numbness or Tingling? Yes No
- Does the pain radiate or travel into your Upper Arm Lower Arm Upper Leg Lower Leg
- How often do you experience these symptoms? 100% 75% 50% 25% 10%
- Pain Intensity: No Pain Mild Pain Moderate Pain Unbearable Pain
- Have you ever been to another doctor for this problem? Yes No
- Doctor \_\_\_\_\_ Date \_\_\_\_\_ • What were the results? \_\_\_\_\_

• **Third Complaint:** \_\_\_\_\_

- Date when symptom first appeared \_\_\_\_\_ • Was the Onset: Gradual Sudden Progressive over Time

• What makes it feel better? \_\_\_\_\_

• What makes it feel worse? \_\_\_\_\_

- Type of Pain: Sharp Dull Ache Burn Throb • Do you experience Numbness or Tingling? Yes No
- Does the pain radiate or travel into your Upper Arm Lower Arm Upper Leg Lower Leg
- How often do you experience these symptoms? 100% 75% 50% 25% 10%
- Pain Intensity: No Pain Mild Pain Moderate Pain Unbearable Pain
- Have you ever been to another doctor for this problem? Yes No
- Doctor \_\_\_\_\_ Date \_\_\_\_\_ • What were the results? \_\_\_\_\_

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

1. What do you hope will happen today as a result of your consultation with the Doctor? \_\_\_\_\_  
\_\_\_\_\_
2. Since your problem became this severe what three things has it caused you to miss the most (ie: work, chores, hobbies, sports, school, leisure activities, time with family or friends?) \_\_\_\_\_  
\_\_\_\_\_
3. How has your life changed since the onset of your problem? \_\_\_\_\_  
\_\_\_\_\_
4. What activities are you limited in? \_\_\_\_\_  
\_\_\_\_\_
5. What kinds of treatments have you received?
 

Epidural:	How Many _____	Date _____	Did it Help? _____
Physical Therapy:	How Long _____	Date _____	Did it Help? _____
Medications:	How Many _____	Date _____	Did it Help? _____
Surgery:	Type _____	Date _____	Did it Help? _____
Other _____		Date _____	Did it Help? _____
6. If you cannot find a solution to this problem what do you think will happen to you? \_\_\_\_\_  
\_\_\_\_\_
7. Describe what you hope the doctor might be able to do for you: \_\_\_\_\_  
\_\_\_\_\_
8. Describe what will be different in your life once your condition improves: \_\_\_\_\_  
\_\_\_\_\_

### My Health Conditions

Please check each of the diseases or conditions that you have now or have had in the past. While some conditions may seem unrelated to this appointment, they can affect diagnosis, care plan, possibility of being accepted for care or having to be referred to another practitioner, if necessary. **C=Current P=Past**

**C P General**

- Allergy
- Convulsions
- Dizziness
- Fatigue
- Headache
- Loss of Sleep
- Loss of Weight
- Anxiety/Depression
- Numbness
- Cancer
- Diabetes
- Thyroid problems
- Epilepsy
- Hyperactivity

**C P Muscle and Joint**

- Arthritis
- Hernia
- Low back pain
- Neck pain
- Pain by shoulder blades

**C P Numbness or Pain in:**

- Shoulders
- Upper arms
- Hands
- Legs
- Feet
- Poor posture
- Swollen joints
- Gout
- Polio

**C P Gastro-Intestinal**

- Constipation
- Diarrhea
- Digestive dysfunction
- Gall Bladder trouble
- Hemorrhoids
- Liver trouble
- Ulcers

**C P Eyes, Ears, Nose, Throat**

- Asthma
- Frequent Colds
- Crossed Eyes
- Deafness
- Ear infections
- Ringing in ears
- Eye pain
- Vision problems
- Nasal obstruction
- Sinus infection

**C P Cardio-Vascular**

- High blood pressure
- Low blood pressure
- Poor circulation
- Irregular heart beat
- Ankle swelling
- Anemia
- Arteriosclerosis
- Stroke

**C P Respiratory**

- Chest pain
- Chronic Cough
- Irregular breathing
- Wheezing
- Emphysema

**C P Genito-Urinary**

- Bed-wetting
- Painful urination
- Prostate trouble
- Blood in urine
- Venereal Disease

**C P Women Only**

- Menstrual cramps
- Excessive menstruation
- Irregular cycle
- Hot flashes

Are you pregnant    Yes    No

**Other(s) not listed:** \_\_\_\_\_

Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

### Sources of Spinal Stress

To help us determine the cause of your problem, please indicate, on this page and the next, potential sources of spinal trauma.

#### General Physical Trauma Falls (Details and Dates)

as infant or child \_\_\_\_\_  
down stairs \_\_\_\_\_  
Other \_\_\_\_\_

#### Exercise

Heavy/Daily    Moderate / Recreational    Periodic

Describe \_\_\_\_\_

#### Primary Daily Activities

sitting    standing    walking    desk work    telephone  
driving    manual repetitive work    heavy lifting

#### Sports and Leisure

Were you, or are you active in any sports?    Yes    No

Describe \_\_\_\_\_

Been hurt or injured in these activities?    Yes    No

Describe \_\_\_\_\_

#### Your Birth

With respect to your own birth process, check all that apply:  
Natural    Epidural/Drug-induced    Premature    C-section  
Breech    Forceps    Vacuum    Pulling/Twisting by doctor

#### Auto Accidents

If your chief complaint is in direct response to a motor vehicle accident, **please notify our staff, as we require a separate questionnaire to document your accident and injury.**

Have you had an accident or near collision in the past, even as a passenger, and even if you did not think you were hurt?  
Yes    No

If yes, please indicate approximate dates and severity below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Family History

1. Does anyone in your family suffer with the same condition(s) you currently have?     No     Yes If yes whom:  
 Grandmother     Grandfather     Mother     Father     Sister's     Brother's     Son(s)     Daughter(s)  
Have they ever been treated for their condition?     No     Yes     I don't know
2. Any other hereditary conditions the doctor should be aware of.     No     Yes: \_\_\_\_\_

### History of Chemical and Personal Stress

#### Medications I am presently taking:

- Painkillers \_\_\_\_\_
  - Anti-inflammatory \_\_\_\_\_
  - Muscle relaxants \_\_\_\_\_
  - Blood pressure medication \_\_\_\_\_
  - Stimulants, Anti-depressants \_\_\_\_\_
  - Tranquilizers, Anti-anxiety \_\_\_\_\_
  - Blood thinners \_\_\_\_\_
  - Birth control pills \_\_\_\_\_
  - Other \_\_\_\_\_
- \_\_\_\_\_  
\_\_\_\_\_

#### Surgeries

Please list all surgeries you had and Dates

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Emergency Contact

Name of a relative or close friend that is not living at my own address that we may contact in case of emergency :

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Telephone \_\_\_\_\_

Eisen Family Chiropractic • 2402 Macy Drive, Roswell GA 30076 • 770.552.1552 • drmattcares.com  
**EISEN FAMILY CHIROPRACTIC (EFC) POLICIES – please check all boxes after reading.**

Over time, individuals accepted as patients gain an understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open area, patients have a unique opportunity to observe first hand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you love.

**PATIENT PRIVACY** – If care is necessary, please note the majority of care takes place in an open area and any conversations you have with the doctor may be overheard by other patients. You consent to any perceptions others may have regarding your treatment. If you have a confidential matter, please let us know and we will schedule time for you and the doctor to speak in a private room. These consultations must be scheduled in advance.

**YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at EFC is rendered primarily to eliminate subluxations, which are a major interference to the expression of the body's God-given, innate wisdom. The doctor uses a myriad of techniques to accomplish this goal, including but not limited to Hand and Instrument Adjustments, Physiotherapy Exercises, and other techniques. Your doctor will outline a course of treatment that will take you beyond simple pain relief, to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health. Prior to receiving care at this office, a history, examination and imaging studies or other diagnostics may also be used in order to confirm the true nature and exact location of subluxations. These procedures are performed to assess your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining chiropractic amenability, as well as the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do to maintain their health for a lifetime.

**X-RAY OFFICE POLICY** - Our policy is to report our exam and x-ray findings to all patients. We would never want to x-ray our patients needlessly. If the doctor decides it is necessary to take any x-rays in our office, you are required to return to the office for your report of findings. Therefore, you agree to return to our office if in fact we do take your x-rays, so that the doctor can discuss the findings and recommendations for your care. You also understand and agree that X-rays taken in this clinic are the property of EFC and will remain in this clinic. Copies of your x-rays can be given on a CD for the purchase of \$25.

**REFERRING TO SPECIALTY PROVIDERS** - We do not offer to diagnose or treat any diseases or condition other than vertebral subluxations. If during the course of your spinal examination, the doctor discovers an unrelated problem, you will be advised to seek a consultation with another specialty provider. Chiropractic is drugless treatment. If you have a goal of getting off prescription medication, it is your responsibility to do so with your medical prescriber.

**RELEASE OF RECORDS** - I hereby authorize **EFC** to release my medical and financial data to my insurance carriers and attorney, when necessary.

**FREQUENCY AND DURATION OF CARE - Adults:** While pain relief may take only a few visits, getting well takes time. Generally speaking, a patient's age, lifestyle, severity of the accompanying symptoms, and the length of time the condition has existed, will play a large role in determining the frequency and duration of their care. The longer the subluxation has existed the more the damage, and the longer it will take to achieve correction and stabilization which takes place during the final phases of a care plan; a goal which is integral to maintaining a healthy spine and nervous system.

**Children:** Young spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxations; therefore, it is best to check children for subluxations and begin any necessary care as young as infancy. It is the policy of this practice to provide spinal check-ups to children up to 18 years of age at minimal charge.

**CARE PLAN INTERRUPTIONS** – In order to complete your first phase of care in the least amount of time with maximum results, it is vital that you follow the recommended clinical course of care outlined by your doctor without exception. That means if you miss an appointment, you must reschedule that appointment for the same, next day, or as soon as possible. If you are going on vacation or out of town for an extended period of time please let the staff and/or doctor know so we can provide you with additional instructions regarding the care of your condition.

**TREATING DOCTOR IN CHARGE OF YOUR CASE** - Like all professions, chiropractors are required to attend continuing education classes for license renewal every year. Additionally your doctor may be called out of town to a conference or speaking engagement. Although your doctor may not be available to adjust /treat patients during his/her absence another qualified doctor, familiar with your case will be managing your care until your doctor returns. It is the policy of this practice to ensure all active patients a continuum or uninterrupted care.

**DISCONTINUING CARE** – Should you decide AT ANY TIME to discontinue care in this office, you must speak to your doctor directly, so that an appropriate assessment as to the status of your health that day, can be made, and documented in your record. This is important should you be injured in an accident in the future and a baseline for liability becomes necessary. Additionally if you have a credit balance on your account, and would like a refund. It is the policy of this practice to refund patients any outstanding credit balance on their account within 30 days of discontinuing. If it is done against the doctors advise you will be required to speak to the doctor personally, or submit to the office, a written statement explain your reason(s) for discontinuing care. Refunds of any credit balance is determined by averaging the cost per patient visit over the entire prepaid package and refunding any unused visits.

**HOLIDAY & OFFICE HOURS/ MVA INSURANCE POLICY** - Office hours are Mon. & Wed. 8am-11:30am & 3pm-6:30pm, Tue. & Thu. 3pm-6:30pm, Fri. 8am-11:30am, and Sat. 9am-11:30am, unless otherwise noted. We reserve the right to close the office due to any emergency, CE seminars, and Holidays. If you are involved in an accident or need to be seen for any other emergency on a weekend or holiday, **we will be happy to see you**. However, you or your insurance will be charged at our full visit rates and the prepaid plan discounts will be suspended until the treatment for the accident or emergency end.

**FEES & PAYMENT FOR SERVICES** - Fees for services are due at the time services are rendered. We have several options for patients to make payments (cash, check, all major types of credit cards, and Care Credit Financing). If you have network insurance and are receiving wellness treatment, you acknowledge that your insurance does not cover your wellness treatment and you instruct us to not bill your insurance.

**BILLING INSURANCE** – We ask our patients to please understand that health and accident insurance policies are a contract between them and their insurance company. We're happy to assist our patients in filing claims for reimbursement and accept any amounts authorized by a patient to be paid directly to Eisen Family Chiropractic. **However it must be clearly understood** that all services rendered are ultimately the individual's responsibility to pay.

**CARING FOR YOUR FAMILY** - it is the policy of this practice to offer the families of all new patients the opportunity to be evaluated by the doctor at no charge as long as the appointment is made within ten days from the date of your first visit or seven from your doctor's report.

**CONSULTATIONS** - This practice offers complimentary consultations to first time new patients.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Authorization Form

## RESPONSIBILITY OF BILL

The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. **Eisen Family Chiropractic** cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include - charges and services not covered by insurance for which payment is denied through any utilization review or pre-certification procedures. I also understand that if I suspend or terminate my care and treatment I, the fees for services rendered me will be immediately due and payable. In the event that of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required for collection.

INITIALS \_\_\_\_\_

## AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to **Eisen Family Chiropractic** for professional services rendered. NO OTHER THIRD PARTY, including attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office.

INITIALS \_\_\_\_\_

## SUBROGATION AND RIGHTS OF REIMBURSEMENT AGREEMENT

If I, or one of my covered dependents receive benefits under my health insurance carrier, hereinafter referred to as Carrier, due to an injury or illness as a result of the acts of a third party, I agree to repay the Carrier any amount of money that I receive from third party or its insurer as compensation for such injuries up to the amount paid out by the Carrier. I understand that this includes the insurer or other agent or if I enter into any form of settlement regarding an accident which I or my covered dependents are injured as a result of the acts of a third party. I will do whatever is reasonably needed to secure the Carriers rights and shall do nothing to damage such rights. I will abide by this agreement only if my health insurance policy contains language that gives the health insurance carrier subrogation and rights of reimbursement.

INITIALS \_\_\_\_\_

## NOTICE OF HIPAA PRIVACY PRACTICE

**EISEN FAMILY CHIROPRACTIC** is required to notify you writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in a report folder labeled 'HIPAA' on the table in the reception area. Once you have read this notice, please sign at the bottom.

### PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any available collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For Public health and safety-in order to prevent, lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI

### YOUR RIGHTS:

To receive an accounting of disclosures, paper copy of the comprehensive "Detail" Privacy Notice, request mailings to an address different than residence, request Restrictions on certain uses and disclosures and with whom we release information to, and request to inspect your records and receive one copy of your records at no charge. And with notice in advance to request amendments to information, however like restrictions we are not required to agree to them.

### QUESTIONS:

If you have further questions or wish to make a formal complaint about how we handle your health information please ask our receptionist to have our privacy coordinator contact you. **Note:** This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of Eisen Family Chiropractic's Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient signature \_\_\_\_\_

Date \_\_\_\_\_