Metta Chiropractic P.C. Today's date: _____

Patient Information

Name: _____
first *middle* *last* *(name you prefer)*

Address: _____
street *apt. #*

_____
city *state* *zipcode*

Who referred you to our office? _____

Your birthday: ____/____/_____ Age: _____ ☐ Male ☐ Female

Social Security #: _____-_____-_____

Occupation: _____

Employer: _____

Marital Status:

☐single ☐married ☐divorced ☐widowed ☐separated

Spouse's name: _____

# of children: _____ Names: _____

Do you have a primary healthcare provider? ☐ Yes ☐ No

When was the last time you consulted him/her? _____

Approximate date of last physical exam: _____

Please provide his/her name, address and phone number:

_____

_____

Contact Information

Home phone: _____ Cell phone: _____

Work phone: _____ E-mail: _____

Best way to reach you: ☐Home ☐Cell ☐Work ☐E-mail

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

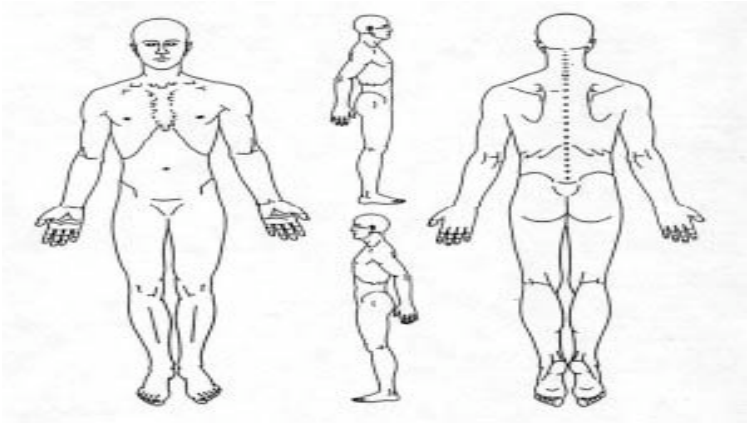
Dr. Paul M Hutchins
METTA CHIROPRACTIC P.C.

Your name: _____ Today's date: _____

Your Health Concerns or Symptoms and How They May Affect Your Life

1) Please describe your health concerns that bring you to our office: _____
_____
_____
_____

Please mark areas of discomfort on the diagram



2) Please indicate the *quality* of your discomfort or pain: ☐dull ☐aching ☐sharp ☐shooting ☐burning ☐throbbing ☐deep ☐other/comments: _____

3) Does the complaint radiate to any other area of your body? ☐yes ☐no Where? _____

4) Is there any numbness or tingling in your body? ☐yes ☐no Where: _____

5) Grade the severity of your pain. 0= no pain 10= worst pain imaginable.
Circle one: **0 1 2 3 4 5 6 7 8 9 10**

6) When did you first experience this complaint? _____

7) How did it begin? _____

8) How often do you notice it? _____ How long does it usually last? _____

9) Does anything make it worse? _____

10) Does anything make it better? _____

11) Have you sought help for this condition in the past? ☐yes ☐no. If yes, please describe diagnoses, treatments, outcome, etc. _____
_____

12) Please indicate the level to which this complaint has affected the following aspects of your life:

0= not at all 1= mildly, but noticeably 2= moderately 3= substantially 4= extremely

Work 0 1 2 3 4 Recreation/Play 0 1 2 3 4 Sleep/rest 0 1 2 3 4 Social life 0 1 2 3 4 Walking 0 1 2 3 4 Sitting 0 1 2 3 4
Exercise 0 1 2 3 4 Appetite 0 1 2 3 4 Love life 0 1 2 3 4 Other: _____ 0 1 2 3 4

Write any further comments here: _____
_____
_____

Your name: _____ Today's date: _____

Health History

1) Have you ever been under the care of another physician for a particular condition? ☐ yes ☐ no
If yes, describe here: _____
_____

2) Have you ever injured your head, neck, spine, back or hips? ☐ yes ☐ no
If yes, describe here: _____

3) Have you ever had a work or motor-vehicle accident related injury? ☐ yes ☐ no
If yes, describe here: _____

4) Please list all medications (prescription and non) that you have taken in the last 60 days (include the reasons for taking them): _____
_____

5) Please list medications including antibiotics that you have taken for extended periods of time in the past: _____

6) Have you ever had x-ray, MRI, CT or other imaging performed? ☐ yes ☐ no If yes, please give date and information on each instance: _____
_____

7) Have you ever undergone any surgical procedure? ☐ yes ☐ no If yes, please describe: _____
_____

8) Have you ever broken a bone or severely sprained a part of your body? ☐ yes ☐ no If yes, describe:
_____

9) Please list any nutritional supplements, herbs or natural remedies that you are currently taking: _____
_____

10) Please list any health problems in your family's history (heart disease, diabetes, stroke, depression, arthritis, cancer, etc.) _____
_____

11) Females only: Are you pregnant? ☐ yes ☐ no Date of last menstrual period: _____

12) Please check any of the following conditions that you have ever experienced to a significant degree:

☐ Alcoholism/addictions
☐ Aneurism
☐ Anxiety
☐ Arm/shoulder pain
☐ Arthritis
☐ Arrhythmia
☐ Asthma/labored breathing
☐ Bad breath
☐ Bladder problems
☐ Cancer
☐ Chronic Fatigue
☐ Depression
☐ Diabetes
☐ Digestive problems
☐ Earache
☐ Epilepsy
☐ Esophageal reflux/heartburn
☐ Frequent or nighttime urination
☐ Grinding of teeth
☐ Headaches
☐ Hearing problems
☐ Heart disease
☐ Hemorrhoids
☐ Herniated Disc
☐ High blood pressure
☐ Insomnia
☐ Irregular menstrual cycle
☐ Irregular/strained bowel habit
☐ Joint aches
☐ Kidney problems
☐ Leg pain
☐ Liver problems
☐ Low-back pain
☐ Lyme Disease
☐ Migraine headaches
☐ Neck pain
☐ Osteoporosis
☐ Parasites
☐ Poor circulation
☐ PMS/severe cramps
☐ Ringing in ears
☐ Sciatica
☐ Stroke
☐ Thyroid problems
☐ TMJ problems
☐ Unexpected weight-gain/loss
☐ Vertigo/dizziness
☐ Yeast infections

Comments/other issues you would like us to be aware of: _____
_____

13) Stressors:
☐ Smoking ___ packs/day
☐ Alcohol ___ drinks/week
☐ Coffee ___ cups/day
☐ Soda pop ___ servings/day
☐regular ☐diet

Exercise:
☐ Minimal (<1x/week)
☐ Moderate (<3x/week)
☐ Frequent (3 or more x/week)
☐ Heavy

Your name: _____ Today's date: _____

Stress Survey

1) On a scale of 1 to 10, ten being extreme stress, I rate my overall stress level at: _____
2) Please rate the level of stress that you experience from each of the following areas of your life:

Physical stress	☐ none	☐ mild	☐ moderate	☐ severe
Family related stress	☐ none	☐ mild	☐ moderate	☐ severe
Personal relationship stress	☐ none	☐ mild	☐ moderate	☐ severe
Work related stress	☐ none	☐ mild	☐ moderate	☐ severe
Childhood related stress	☐ none	☐ mild	☐ moderate	☐ severe
Financial stress	☐ none	☐ mild	☐ moderate	☐ severe
Loss of a loved one	☐ none	☐ mild	☐ moderate	☐ severe
Other:_____	☐ none	☐ mild	☐ moderate	☐ severe

Dietary Information

1) How important is it to you to eat well? ☐ not important ☐ important ☐ very important
2) Are you aware of any food allergies- mild or severe? ☐ yes ☐ no If yes, describe: _____
_____
3) Are you currently trying to lose or gain weight? ☐ yes (☐ lose ☐ gain) ☐ no
4) Sugar: ☐ never touch it! ☐ minimal amounts ☐ a fair amount ☐ a lot ☐ I crave sugar/sweets!
5) Water: ☐ no thanks! ☐ 1-3 glasses/day ☐ 4-6 glasses/day ☐ 6-8 glasses/day ☐ 9+ glasses/day
We recommend drinking at one liter of pure water per 50 lbs. of body weight to maintain your health
6) Do you use artificial sweeteners? ☐ yes: _____ ☐ no

Your Wellness Goals

In order for your doctor to be the best possible ally for you as you choose to take control of your health, please indicate the level of care that you are interested in pursuing at Metta Chiropractic:

☐ Corrective Care:
Select this option if you are interested in getting out of pain or resolving your chief-complaint and nothing more.

☐Preventative/maintenance Care:
Select this option if, beyond resolving your current complaint, you would like to have your spine and other body systems checked on a regular basis to help insure your ongoing health, vitality and well-being.

☐Wellness/development Care:
Select this option if you are ready to put all of our resources to use for you on your journey of health, vitality and physical, mental, emotional and spiritual development.

Payments

Due to ethical and philosophical considerations, Metta Chiropractic does not deal directly with insurance companies or Medicare. We will however, upon request, be happy to furnish you with a "superbill" that you can submit to your insurance carrier for reimbursement provided that chiropractic care is covered in your plan.

Payment is appreciated in full on the day services are rendered. We gladly accept cash, check and major credit cards.

Patient signature: _____ Date: _____

Doctor's signature: _____ Date: _____

Metta Chiropractic, P.C.
Dr. Paul M Hutchins
17 Glen Pond Rd.
Red Hook, NY 12571
Tel: (845) 758-5507 Fax:(845) 758-5511

Date:_______

Informed Consent for Treatment and Care

I hereby request and consent to the performance of chiropractic, applied kinesiology and medical procedures, including various modes of physical therapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Paul M Hutchins and/or other licensed professionals who now or in the future treat me while employed by or associated with Metta Chiropractic or Paul Hutchins D.C.

I understand and am informed that, as in the practice of medicine, there are some risks to chiropractic treatment. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise his or her best judgment during the course of my treatment and to choose procedures which the doctor feels at the time, based upon the facts then known, are 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 receive examinations and treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's
Signature:_____Date_____

Signature of Representative if Patient is a Minor or Physically or Legally Incapacitated:
_____Date_____

Relationship or Authority of Patient's Representative_____

Metta Chiropractic, P.C.
Notice of Privacy Practices and Phone Practices

The purpose of this form is to inform you, the patient, of the policy of Metta Chiropractic, P.C. regarding the Health Insurance Portability and Accountability Act (HIPPA) and your Personally Identifiable Health Information (PHI).

Metta Chiropractic, P.C., in compliance with HIPPA, requires that you sign an authorization form stating the policy of the office is to protect your Personally Identifiable Health Information (PHI). We require your signed permission to release any protected information regarding your health to any entity such as insurance company, business employer or Attorney.

The policy of Metta Chiropractic, P.C., in compliance with HIPPA, is not to release any information about your health or treatment with us to anyone without your expressed personal permission in writing.

In addition, as a courtesy, we like to call all our patients one business day before their scheduled appointment as a reminder. With everyone's busy schedules, we may need to leave a message on an answering machine, or with someone else within the household (significant other, parent, or child). If this is not acceptable, please sign below and mark the appropriate box. Again, if this is not wanted, please sign below and mark the appropriate box. Thank you!

I,_____, have read the above information and understand the privacy policy of Metta Chiropractic, P.C.

Sign:_____ Date:_____

I accept the office calling as a courtesy to remind me of my appointment the day before and allow them to leave a message if necessary. ❑ YES ❑ NO

Sign:_____ Date:_____