Date of Visit: ___/___/___ Patient: ________________________________ Age: _____

What brought you here today? ____

____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES

PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: ______________________________

____

Past Hospitalizations: ______________________

____

Surgeries: __________________________________

____

Medications: ________________________________

Patient Signature: X ____

(DO NOT WRITE BELOW THIS LINE)

EXAMINATION

Range of Motion

Cervical	Normal		Pain
Flexion	50		
Extension	60		
Left Lat Flex	45		
Right Lat Flex	45		
Left Rotation	80		
Right Rotation	80		
Lumbar	**Normal**		**Pain**
Flexion	60		
Extension	25		
Left Lat Flex	25		
Right Lat Flex	25		
Left Rotation	30		
Right Rotation	30		

Health HX Notes:

____

____

____

____

____

____

Asymmetry

C0
C1
C2
C3
C4
C5
C6
C7
L1
L2
L3
L4
L5
SAC
L-IL
R-IL

Using arrows (↑ ↓ → ←) mark the misaligned vertebrae

T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12

Using arrows (↑↓), mark postural asymmetry

Tissue

Mark tissue abnormalities
TP, LG, TN, SK, FS

TP=Trigger Points; LG=Ligaments (swollen or tender)
TN=Tendons; SK=Skin; FS=Fascial Restrictions

HISTORY OF PRESENT COMPLAINT

Complaint: ______________________________

Qual & Chara: ______________________________

On, Dur, Intens, Freq, Loc, Rad ______________________________

____

____

Better or worse ______________________________

____

Prior TX, meds, other: ______________________________

____

EXAMINATION

Reflexes
(Wexler Scale)

Biceps ____
Triceps ____
Brac/rad____
Patella ____
Achilles ____

B/P: ___/___ **PULSE:** ____ **RESP:** ____ **HT:** ____ **WT:** ____ **GRIP: (R)** ____ **(L)** ____

Sensory: C5: _____ C6: _____ C7: _____ C8: _____ T1: _____
L3: _____ L4: _____ L5: _____ S1: _____
D= Deficit N= Normal (R) or (L)

General Orth/Neuro Examination:
Spinous Percus: _____ Valsalva: _____
Dejerine Triad: _____ Rhomberg: _____ **(+) or (-), (R) or (L)**

Notes: ______________________________

Test	(+)	(-)	R	L	Indication
Distraction					nerve root compression
Jackson					nerve root compression
Max Cerv Rot Comp					nerve root compression
Cerv Comp					nerve root compression
Soto Hall					(cerv) (thor) vertebral trauma
Spurlings					nerve root irritation
Shoulder Depress					nerve root compression

	(+)	(-)	R	L	Indication
Libman's					(low) (normal) (high) pain threshold
Burn's Bench					(hysteria) (malingering)
Hoover's					(hysterical paralysis) (malingering)

	(+)	(-)	R	L	Indication
Bechterew					sciatic disk compression
Beevor's					abdominal muscle weakness
Minors Sign					radicular disk pain
Ely					upper lumbar lesion
Fajersztajn					intervertabral disk syndrome
Nachlas					upper lumbar lesion
Gluteal punch					spinal lesion
Goldthwaite					lumbar differentiation
Heel walk					5th lumbar motor deficit
Kemps					intervertebral disk rupture
Lasague					(muscle) (disk) (nerve) irritation
Braggards					lumbar antalgic spasm
Supported Adam's					lumbosacral differentiation

MUSCLE TESTS

Level	Muscle	Muscle Grade	
C5	Deltoids	L:	R:
C6	Biceps	L:	R:
	Wrist extensors	L:	R:
C7	Triceps	L:	R:
	Wrist flexors	L:	R:
	Finger extensors	L:	R:
C8	Finger flexors	L:	R:
T1	Finger abductors	L:	R:
L2 -L3	Hip flexors	L:	R:
L4-L5	Hip extensors	L:	R:
L3-L4	Knee extensors	L:	R:
L5-S1	Knee flexors	L:	R:
L4-L5	Ankle extensors	L:	R:
S1-S2	Ankle flexors	L:	R:

TREATMENT PLAN

Initial TX on: ___/___/___

Level of Care: (include duration and frequency of visits)

____

____

____

Specific Treatment Goals: ______________________________

____

Specific Objective Eval: ______________________________

____

____

DIAGNOSIS: ______________________________

____

____

Doctor Signature: ______________________________ **Date:** ___/___/___

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www.chirocode.com • (602) 944-9877

PATIENT INFORMATION

TODAY'S DATE ____

NAME ____

ADDRESS ____

CITY ____________________ STATE ______ ZIP __________

BIRTHDATE ____

HOME PHONE ____

WORK PHONE ____

CELL PHONE ____

EMAIL ____

Dr. Graeme Van Matre
4013 Westfield Road, Westfield, IN 46062
PO Box 732, Westfield, IN 46074

INFORMED CONSENT FOR CHIROPRACTIC ADJUSTMENTS AND CARE

To the patient (or their parent, legal guardian, court appointed conservator, or agent): Please read this entire form prior to signing it. It is important that you understand the information contained in this form. Please ask any questions prior to signing this form if you are unclear about anything in this form.

Chiropractic Adjustments-The primary treatment rendered by the Doctor of Chiropractic to you will be chiropractic adjustments, which are purposely intentioned movements of bones with the desired effect being to remove interferences to nerves, which then allows your body to use its innate ability to heal itself. Chiropractic adjustments also have the desirable effect of enabling muscles, tendons, and ligaments to properly function and heal, and also allows blood flow to properly occur. Chiropractic adjustments can be made by either the use of hands or mechanical instruments to any bone or joint in the body including both spinal and extremity bones. You may or may not hear an audible sound, which is just air being released from the joint space as bones are moved into their proper positions.

Other Procedures-There are a number of other procedures that Doctors of Chiropractic may use on you. A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, range of motion testing, muscle strength testing, and various neurological and orthopedic testing. Treatment may include chiropractic adjustments and physical therapy (such as ultrasound, massage therapy, and exercise recommendations). Additionally, there may be referrals to other doctors as necessary and their treatment should involve the same informed consent with disclosure of risks and benefits as being done here.

Material Risks Inherent with Chiropractic Adjustments and Other Treatment-As with any healthcare procedure, there are certain complications which may arise when chiropractic adjustments and other care/procedures are performed. These complications include but are not limited to fractures of bones, disc injuries, dislocations, muscle strains, cervical myelopathy, strokes, radiation exposure, costovertebral strains and separations, and burns. Some patients feel some stiffness and/or soreness following the first few days of treatments. The physical exam can temporarily worsen symptoms, but it is a necessary part of chiropractic care. The Doctor of Chiropractic will make every reasonable effort during the examination to screen for contraindications to care, but remember it is your responsibility to inform the Doctor of Chiropractic of any conditions that would not otherwise come to their attention.

Probability of Risks Occurring-Fractures are rare occurrences and generally result from some underlying bone weakness. Even though a competent history and examination will be performed, it is still possible for some weakness of bone to be undetected. Extremely rare are strokes from vertebral artery dissection which also occur in about one person in 133,000 in general (not related to chiropractic), but are estimated to occur in between one in one million and one in five million cervical adjustments. Although discs are generally helped with chiropractic care, they can be worsened even to the point of requiring surgical care; however, this rarely occurs. Physical therapy can sometimes burn skin by irritating it, although this is unlikely to occur.

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND UNDERSTAND THIS FORM. UPON DOING SO, PLEASE COMPLETE THE INFORMATION AND SIGN THIS FORM

____ ____________________

Signature of Patient/Legal Guardian Date

____

Patients Printed Name

Time of Service Agreement

Any patient wishing to pay for treatment at the time services are rendered may do so under the following terms and conditions. The payer must agree to all terms outlined below and must sign and date this agreement.

- Beginning January 1, 2023, if paying at the time and date that the services are rendered, all treatment by Dr. VanMatre including spinal and other adjustments as well as any physical therapy performed, and exercise instructions given by Dr. VanMatre will be charged at a rate of $130 for a first visit and $65 for subsequent visits. Payment must be made at the time services are rendered to receive the aforementioned rates. Payments can be made by cash, check, Mastercard, Visa, and Discover. If payment is not made at the time services are rendered, the rates will be $140 for a first visit and $75 for subsequent visits.
- Orthotics will be charged at a rate of $400.00 if payment is made at the time of service.
- This office will not be responsible for filing any insurance under this agreement.
- This office will not be responsible for generating any claim forms.
- This office will not be held responsible or support medical necessity under this agreement.
- This office will not generate any reports or documentation on treatment under this agreement.
- When requested, any person under this agreement will receive a receipt in the form of a "superbill", which will contain date of service, procedures, diagnosis, and payments made when services are/were rendered.
- Any person under this agreement may use the superbill receipt to submit their own insurance claim, or for whatever means they choose.
- This agreement can be terminated in writing at any time in the future and must be terminated in writing before this office is able to bill anyone else for your services/treatment, and supplies.

I have read this document entirely and agree to all the terms and conditions outlined above.

Signature: ______________________________ Date: ____________________

(Print Name): ________________________________

Dr. Graeme VanMatre
317-496-3624
docvanmatre@gmail.com

Termination Date: ______________ Patient Signature: ______________________________

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. This Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.

The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.

The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by: ______________________________

Printed name-Patient or Responsible Party

______________________________ ______________

Patient Signature of Responsible Party Date

____

Relationship to Patient (if other than patient)

Witness: ______________________________

Printed Name of Practice Representative

______________________________ ______________

Signature Date

WESTFIELD SPINE & SPORT
Dr Graeme VanMatre | 317-496-3624

DRY NEEDLING CONSENT AND REQUEST FOR PROCEDURE

What is Dry Needling? Dry needling is a form of therapy in which fine needles are inserted into myofascial trigger points (painful knots in muscles), tendons, ligaments or around nerves in order to stimulate a healing response in painful musculoskeletal conditions. Dry needling in not acupuncture or Oriental Medicine; that is, it does not have the purpose of altering the flow of energy ("Qi") along traditional Chinese meridians for treatment of disease. In fact, dry needling is a modern, science-based intervention for the treatment of pain and dysfunction in musculoskeletal conditions such as neck pain, shoulder impingement, tennis elbow, carpal tunnel syndrome, headaches, knee pain, shin splints, plantar fasciitis or low back pain. Dry needling is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: Drowsiness, tiredness, or dizziness occurs after treatment in small number of patients (1-3%) and if affected, you are advised not to drive. Minor bleeding or bruising occurs after dry needling in 15-20% of treatments and is considered normal. Temporary pain during needling occurs in 60-70% of treatments. Existing symptoms can get worse after treatment in less than 3%; however, this not necessarily a "bad" sign. Fainting can occur in certain patients (.3%), particularly at the first treatment session when needling head or neck regions. The most serious risk with dry needling is accidental puncture of a lung (pneumothorax) in .01%. ` If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications, which may result.

Please answer the following questions:

Are you pregnant? Yes No **Are you immunocompromised?** Yes No **Are you taking blood thinners?** Yes No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

You have the right to withdraw consent for this procedure at any time before it is performed.

______________________________ ______________________________

Patient or Authorized Representative (signature) Printed name

______________________________ ______________

Relationship to patient (if other than patient) Date:

Physical Therapist Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

______________________________ ______________

Physical Therapist Date