



Patient Name: _____ What you preferred to be called?: _____

Birthdate: ___/___/___ Age: ___ Male Female E-Mail Address: _____

Physical Address: _____ City, State, Zip: _____

(STUDENTS— please put your local address here)

Cell Phone #: _____ Work Phone #: _____ Home Phone #: _____

For your appointment confirmations: (please choose one option)

Phone Call (choose one) Email Text Message (cell phone number required)

Home Work Cell

Status: Minor Single Married Divorced Separated Widowed Spouse's Name: _____

Do you have children? No Yes How Many: _____ Referred by: _____

Employer: _____ Employer's Address: _____

Account Information: Person ultimately responsible for account.

Name: _____ Relation: _____ Phone: _____

Billing Address: _____ City, State, Zip: _____

(STUDENTS— please put your parents address here, if appropriate for billing)

Drivers License #: _____ Payment Method: Cash Check Credit

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

1. Is today's problem caused by:

Auto Accident Workman's Compensation Claim Neither

2. What is your main area of complaint? _____

3. How often do you experience your symptoms?

Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

Sharp Numb Sharp with motion
 Dull Tingly Shooting with motion
 Diffuse Achy Stabbing with motion
 Burning Stiff Electric like with motion
 Shooting Other: _____

5. How are your symptoms changing with time?

Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your condition?

Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. What concerns you the most about your problem; what does it prevent you from doing?

IN THE EVENT OF EMERGENCY

Who should we contact?

Relationship to you:

Phone: _____
Other #: _____
Who is your Medical Doctor?

Medical Doctor's phone #: _____

FOR OFFICE USE ONLY

Pt file #: _____
BP: _____
Pulse: _____

11. How long have you had this problem? _____

12. How do you think your problem began? _____

13. Do you consider this problem to be severe?
 Yes Yes, at times No Bothersome

14. What aggravates your condition? _____

15. What alleviates your condition? _____

16. What is your: Height _____ Weight _____ Occupation _____

17. How would you rate your overall Health?
 Excellent Very Good Good Fair Poor

18. What type of exercise do you do?
 Strenuous Moderate Light None

19. Indicate if you have any immediate family members with any of the following:
 Rheumatoid Arthritis Diabetes Lupus None
 Heart Problems Cancer ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

<u>PAST</u>	<u>PRESENT</u>	<u>PAST</u>	<u>PRESENT</u>	<u>PAST</u>	<u>PRESENT</u>
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss	For Females Only	
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other:	
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular In-coordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		

21. List all prescription medications you are currently taking: (If you have a list, we can copy it): _____

22. List all of the over-the-counter medications & vitamins you are currently taking: _____

23. List all surgical procedures you have had and approximate dates: _____

24. What activities do you do at work or at home?

- Sit:** Most of the day Half the day A little of the day
Stand: Most of the day Half the day A little of the day
Computer work: Most of the day Half the day A little of the day
On the phone: Most of the day Half of the day A little of the day
Drives: Most of the day Half of the day A little of the day
 Performs manual labor
 Reads a lot
 Travels Frequently

25. What activities do you do outside of work? Activities or hobbies: _____

26. Have you ever been hospitalized? No Yes If yes, why _____

27. Have you seen a Chiropractor before? No Yes If yes, how long ago? _____

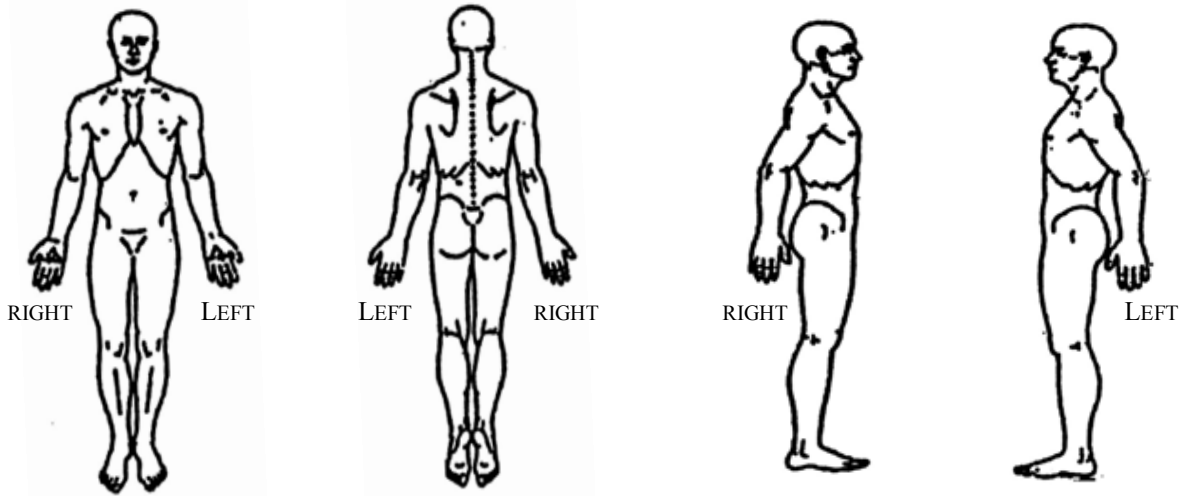
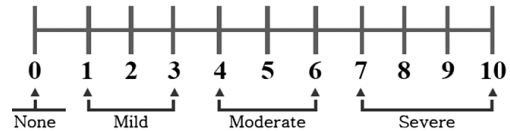
How were your results? Great Good Fair Mixed Poor Other _____

28. Have you had significant past trauma? No Yes

29. Please mark area(s) of injury or discomfort using

- A) Letters to describe your pain**
B) Numbers for the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

- N = Numbing
- P = Pins & Needles
- B = Burning
- A = Aching
- S = Stabbing



30. Anything else pertinent to your visit today? _____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requests payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature _____ **Date:** _____

Would you be willing to help us out?

If so, please answer each question. Check all that apply.

For helping us out, we will donate \$1 to a local non-profit group! Help us, so we can help others!

1. Pick a (ONE) local non-profit group for \$1 to be donated from Heresco Chiropractic for answering the following questions.

- Linn Benton Food Share Jackson Street Youth Shelter Philomath Youth Activities Club Corvallis Aquatic Team
 CARDV Safehaven Humane Society Home Life Girls on the Run Willamette Valley

2. I heard about Heresco Chiropractic from my (answer all that apply)?

- Clinic Reputation Another Chiropractor Family Member Other _____
 Family Physician Insurance Agent Friend I did NOT hear about Heresco
 Attorney Claims Adjustor Co-Worker Chiropractic from any of these resources.

3. In reference to question 2, what is the name of the person/company who referred you to our clinic?

4. Have you seen Heresco Chiropractic at an event? Which events have you seen us at?

- Run/Walk Events Community Health Fairs OSU Events Other _____
 Sporting Events Business Health Fairs Lunch and Learn Presentation I have NEVER seen Heresco
Chiropractic at any local events.

5. In reference to question 4, what is the name of the event you saw Heresco Chiropractic at?

6. Were you referred to one of the chiropractors in this office? (answer all that apply):

- Dr. Frank Heresco Dr. Joshua Ort Dr. Joseph Shepro Dr. Cory Ann Imhof Other _____

7. I have heard or found Heresco Chiropractic through the following media sources:

- Facebook Yelp Student Survival Kit Newspaper
 Heresco website Dex Media Telephone Book Other _____
 Googled "chiropractor" Name of internet search engine: _____ Magazine I have NOT heard of Heresco
Chiropractic from any of these media sources.

Thank you for helping us out!