Heresco CHIROPRACTIC
massage • strength rehab

Today's Date: ____/____/____

Patient Name: ______________________________ What you preferred to be called?: ____________
First Last MI

Birthdate: ______/______/______ Age: ______ Gender: ____________ Email: ______________________

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*) ❑Text Message (cell phone number required)
❑Home ❑Work ❑Cell

Relationship Status: ______________________ Do you have children? ❑No ❑Yes How Many: ________

Name of Employer: ______________________ Job Title: ______________________

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)

____________ *I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.*
Initials *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: ______________

Patient Name: **Pt. File#:** ***Welcome***

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 ______

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.

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

Patient Name: **Pt. File#:** ***Welcome***

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?____________________

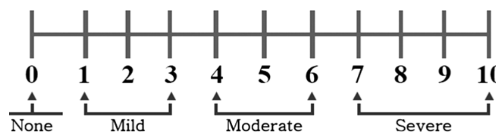
How were your results? □ Great □ Good □ Fair □ Mixed □ Poor □ Other ____________________

28. Have you had significant past trauma? □ No □ Yes

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

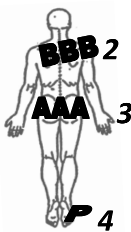
A) Letters to describe your pain

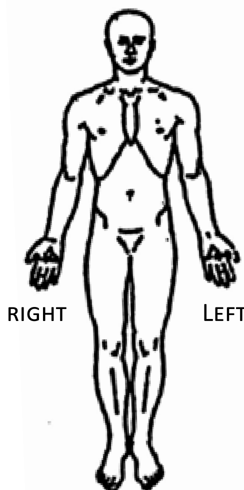
B) Numbers for the degree of pain using a scale from

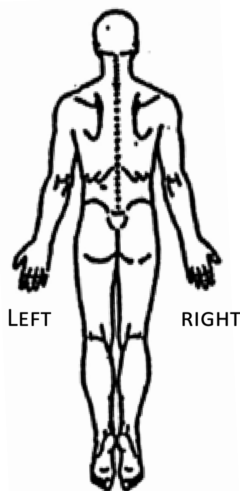


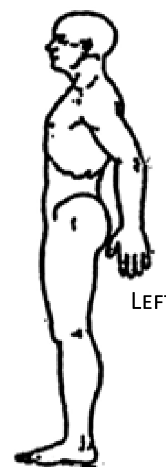
1 (discomfort) to 10 (extre

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









30. Anything else pertinent to your visit today? ____________________

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- 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:** ____________________

Patient Name: **Pt. File#:**

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/Company ☐ Friend ☐ I did NOT hear about Heresco Chiropractic from any of these resources.

☐ Attorney ☐ Claims Adjustor ☐ Co-Worker

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. Joseph Shepro ☐ Dr. Cory Imhof ☐ Dr. Michael McDonald ☐ Dr. Loren Hanna ☐ Other__________________

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

☐ Facebook ☐ Name of internet search engine: ____________________ ☐ Drove By the office ☐ Newspaper

☐ Heresco website ☐ Student Survival Guide ☐ Other _______________________

☐ Googled "chiropractor" ☐ Printed Advertisement ☐ Telephone Book ☐ I have NOT heard of Heresco Chiropractic from any of these media sources.

☐ Yelp ☐ Radio Advertisement ☐ Magazine

Thank you for helping us out!