

Southern Oregon Sports and Spine

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PATIENT INFORMATION FORM

TODAY'S DATE _____

PATIENT NAME _____ PREFERRED NAME _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

MAILING ADDRESS (if different from above)

STREET OR PO BOX _____ CITY _____ ST _____ ZIP _____

HOME PHONE# _____ CELL PHONE# _____

EMAIL ADDRESS _____

BIRTH DATE _____ AGE _____ HEIGHT _____ WEIGHT _____

SS # _____

REFERRED BY _____

EMPLOYER'S NAME AND ADDRESS _____

YOUR PRIMARY HEALTHCARE PROVIDER _____ PHONE# _____

EMERGENCY CONTACT _____ PHONE# _____

INSURANCE _____ SUBSCRIBER'S NAME _____

SUBSCRIBERS DATE OF BIRTH (IF NOT PATIENT) _____

SPOUSE'S NAME _____ WORK PHONE# _____

SPOUSE'S EMPLOYER _____ ADDRESS _____

SPOUSE'S BIRTHDATE _____

WHO IS RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING TODAY BY CASH _____ CHECK _____ CREDIT CARD _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature

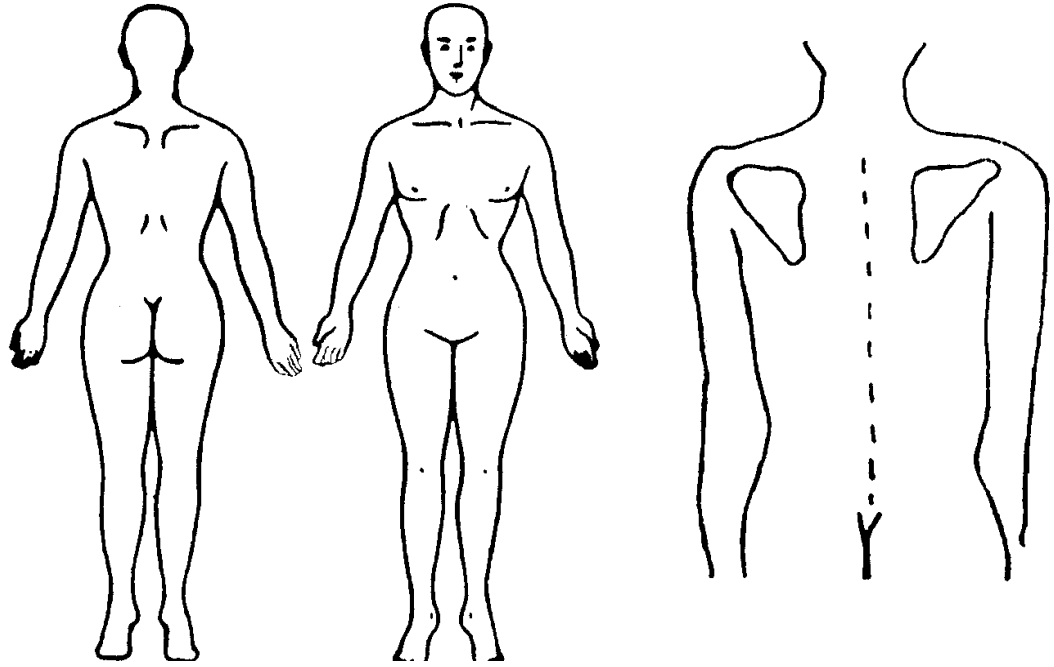
Date

Parent (if minor)

Date

1. Please indicate where your pain is located. Indicate the appropriate location using the SYMBOL that best describes the discomfort you are presently experiencing.

- Sharp & Stabbing = *
- Dull & Achy = V
- Pins & Needles = O
- Numbness = /



2. Describe your symptoms and/or pain. (Where do you hurt?) _____

3. Type of pain (Circle one or more)
- | | | |
|--------------|--------------|-------------------------|
| a. dull ache | d. burning | g. numbness or tingling |
| b. sharp | e. deep | h. other _____ |
| c. shooting | f. radiating | |

4. Please list any associated symptoms (i.e. leg pain, fatigue, irritability, headache, difficulty sleeping, etc.)

5. Please mark your pain level on the 1 to 10 scale with a vertical line, with 0 being “no pain” and 10 being the maximum pain you can imagine.

	No Pain	Intolerable
NOW	0 1 2 3 4 5 6 7 8 9 10	
AT WORST	0 1 2 3 4 5 6 7 8 9 10	
AT BEST	0 1 2 3 4 5 6 7 8 9 10	
AVERAGE	0 1 2 3 4 5 6 7 8 9 10	

6. Did the problem start a) gradually _____ or b) suddenly _____?
7. Describe **how** it began. What started your pain—any trauma or unusual events? _____

8. **When** did your pain begin? _____
9. What % of the time are you in pain? ____ 0-25% ____ 25-50% ____ 50-75% ____ 75-100%
10. Is the problem constant ____ or off and on ____? How long does it last? _____
11. Is pain worse in morning? ____, late in the day ____, at night ____, or other _____
12. Compared to when it started, is your pain better ____ worse ____ or the same ____?
13. What other treatment have you had? _____
14. What makes the pain better (heat, ice, medication, laying down, moving, other)? _____

14. What makes it worse (coughing, sitting, getting up from sitting, twisting, sneezing, etc.)

15. How does this problem affect you, specifically your lifestyle, recreation, work, relationship, what can't you do comfortably any more? _____

16. Have you had problems with this area before? ____ Describe them and how long you've had them. _____

17. List any medication(s) you are now taking: _____
18. Please list any pertinent surgeries or hospitalizations: _____
19. Do you feel your work or lifestyle contribute to the problem? ____ If so, please describe.

20. Are there any secondary problems you want to talk to the Doctor about? _____

21. Any known birth defects or deformities? _____
22. Traumas (Give date of trauma and body part involved)
- Vehicle Accidents _____
 - Work Injuries _____
 - Sports Injuries _____
 - Slip/Fall Injuries, Lifting Injuries _____
 - Concussions _____
 - Fractures/Dislocations _____
 - Birth Trauma _____
 - Childhood physical/sexual abuse _____
 - Other Injuries _____

SOUTHERN OREGON SPORTS & SPINE MEDICAL HISTORY

REVIEW OF SYSTEMS FORM

DATE: _____ NAME: _____ DATE OF BIRTH _____
 ___ MARRIED ___ SINGLE ___ DIVORCED ___ WIDOWED; OCCUPATION: _____
 NO. OF CHILDREN: ___ TOBACCO USE: YES/NO HOW MUCH? ___/DAY HOW LONG? DATE QUIT _____
 ALCOHOL USE: YES/NO HOW MUCH? ___/DAY CAFFEINE (COFFEE, TEA, COLAS) PER DAY _____

REVIEW OF SYSTEMS-PLEASE CIRCLE EACH ITEM OR "NONE" AS THEY RELATE TO YOUR HEALTH

<p><u>CONSTITUTIONAL</u> NONE</p> <p>Fatigue</p> <p>Fever</p> <p><u>MUSCULOSKELETAL</u> NONE</p> <p>Osteoporosis</p> <p>Arthritis</p> <p>Joint Pain</p> <p>Other: _____</p> <p><u>NEUROLOGICAL</u> NONE</p> <p>Anxiety</p> <p>Headaches</p> <p>Dizziness/Vertigo</p> <p>Memory Loss</p> <p>Numbness</p> <p>Seizures</p> <p>Other: _____</p> <p><u>EYES</u> NONE</p> <p>Glasses/Contacts</p> <p>Double Vision</p> <p>Cataracts</p> <p>Other: _____</p> <p><u>EAR, NOSE, THROAT</u> NONE</p> <p>Difficulty Hearing</p> <p>Ringing in Ears</p> <p>Sinus Trouble</p> <p>Other: _____</p> <p><u>ALLERGIES/IMMUNE</u> NONE</p> <p>Hives/Eczema</p> <p>Hay Fever</p> <p>Other: _____</p>	<p><u>CARDIOVASCULAR</u> NONE</p> <p>Chest Pain</p> <p>Shortness of Breath</p> <p>Stroke</p> <p>Murmur</p> <p>Palpitations</p> <p>Heart Disease</p> <p>High Cholesterol</p> <p>High Blood Pressure</p> <p>Fainting Spells</p> <p>Dizziness</p> <p>Difficulty Laying Flat</p> <p>Swelling Ankles</p> <p>Other: _____</p> <p><u>RESPIRATORY</u> NONE</p> <p>Asthma</p> <p>Cough</p> <p>Coughing Blood</p> <p>Wheezing</p> <p>Chills</p> <p>Other: _____</p> <p><u>ENDOCRINE</u> NONE</p> <p>Diabetes</p> <p>Weight Loss/Gain</p> <p>Loss of Hair</p> <p>Heat/Cold Intolerance</p> <p>Other: _____</p> <p><u>MENTAL</u> NONE</p> <p>Depression</p> <p>Alcohol/Substance Abuse</p> <p>Other: _____</p>	<p><u>GASTROINTESTINAL</u> NONE</p> <p>Heartburn/Reflux</p> <p>Nausea/Vomiting</p> <p>Constipation</p> <p>Diarrhea</p> <p>Black/Bloody Stools</p> <p>Changes In BM</p> <p>Abdominal Pain</p> <p>Jaundice (yellowish skin)</p> <p>Other: _____</p> <p><u>HEMATOLOGY/LYMPH</u> NONE</p> <p>Bruise Easy</p> <p>Gums Bleed Easy</p> <p>Enlarged Glands</p> <p>Other: _____</p> <p><u>SKIN</u> NONE</p> <p>Rash/Sores</p> <p>Itching/Burning</p> <p>Dryness</p> <p>Other: _____</p> <p><u>GENITOURINARY</u> NONE</p> <p>Burning/Frequency</p> <p>Blood In Urine</p> <p>Incontinence</p> <p>Other: _____</p> <p><u>OTHER KNOWN CONDITIONS</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES AS BEST YOU CAN)

PAST OR PRESENT ILLNESSES OF YOUR FAMILY: (CIRCLE ALL THAT APPLY)

ALCOHOLISM ANEMIA ASTHMA CANCER/TUMOR DIABETES DEPRESSION EPILEPSY/SEIZURES GLAUCOMA HEART DISEASE	HIGH BLOOD PRESSURE KIDNEY DISEASE LIVER DISEASE HEPATITIS HIGH CHOLESTEROL HIV/IMMUNE DISEASE LUNG DISEASE MENTAL ILLNESS OSTEOARTHRITIS	OSTEOPOROSIS PHLEBITIS RHEUMATIC ARTHRITIS STROKE THYROID DISEASE TUBERCULOSIS / TB ULCER IN GI TRACT OTHER: _____
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Marc Heller, DC, PC
Matt Terreri, DC
Ann Michael, DC



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Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Marc Heller, Dr. Matthew Terreri and Dr. Heather Escobar, hereafter to be referred to in this document as Southern Oregon Sports and Spine, for all chiropractic services, rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Southern Oregon Sports and Spine to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing.

I have requested chiropractic services from Southern Oregon Sports and Spine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered, unless other arrangements have been made in advance with our business manager, and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

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Matt Terreri, DC
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What to expect after your first adjustment

Most of the time, you will feel better after your first treatment. You probably won't feel 100% but you may have a greater sense of ease and ability to move more freely with decreased pain. If you have been in pain for longer than a few days then it usually takes longer to get relief.

Keep in mind your body is adapting to new positioning, alignment and freedom. The first night or the next day after the first treatment symptoms that you came in with may increase - occasionally dramatically. This reaction happens to about 30% of our patients and it is hard to predict to whom this will happen. Within 24-48 hours, you will usually start to feel better.

If you do have a negative reaction to the first treatment and it is not diminishing by the end of the second day, please call us. We should see you as soon as possible if the pain is not diminishing. It is often simple to resolve this type of continuing reaction with the right treatment.

Even if you feel better, it is important to use common sense, do your exercises and choose the right level of activity to support your healing. In other words, don't over do it! Small movements are generally better than none, and we will teach you correct movement/exercise patterns during your visits here.

If you are still hurting, ice is almost always safe and often gives good temporary relief. Use ice for 15-20 minutes, at least until the area becomes numb. You can use ice frequently up to once per hour. You can use an ice gel pack, a sack of frozen peas or corn, a zip-lock bag filled with ice cubes or ice cubes and water. Try to keep the rest of your body warm and comfortable while you are icing. The coldness may initially burn or hurt but should help block the pain by the time you are numb. Use a thin layer of cotton between your skin and the ice bag to prevent an ice burn to your skin.

Please let us know before you leave the office if you are feeling worse than when you came in.

MARC HELLER, DC; MATT TERRERI, DC and ANN MICHAEL, DC

I have read and understand the above information.

Signature

Date

FUTURE APPT. NOTIFICATION METHOD

TO OUR PATIENTS:

WE CAN NOW NOTIFY YOU OF YOUR UPCOMING APPOINTMENTS VIA TEXT MESSAGING OR EMAIL RATHER THAN A PHONE CALL.

PLEASE INDICATE YOUR PREFERENCE ALONG WITH YOUR CELL PHONE NUMBER AND CELL PHONE PROVIDER (CELL PHONE NETWORK) AND/OR EMAIL ADDRESS.

THANKS!

NAME _____

I WOULD PREFER TO RECEIVE MESSAGES BY:

TEXT MESSAGE.

MY CELL PHONE NUMBER IS: _____

MY CELL PHONE PROVIDER IS: _____

YOUR CELL PHONE NETWORK/PROVIDER WILL BE ONE OF THE FOLLOWING:
AT&T, BOOST MOBILE, CRICKET, METRO PCS, NEXTEL, SPRINT, T-MOBILE,
US CELLULAR, VERIZON

EMAIL MESSAGE.

MY EMAIL ADDRESS IS: _____

Southern Oregon Sports and Spine

Marc Heller, D.C.

Matthew Terreri, D.C.

Ann Michael, D.C.

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541-482-0625

Patient Informed Consent to Treatment

Patient Name: _____

I hereby request and consent to the performance of chiropractic adjustments and other therapeutic procedures by Marc Heller, D.C., Matthew Terreri, D.C., and/or Ann Michael, D.C. and/or the staff of licensed professionals of Southern Oregon Sports and Spine and Marc Heller, P.C. who now, or in the future, treat me in this office.

The most common side-effect of chiropractic treatment is short-term (12-36 hours) soreness. The more severe risks are rare.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some rare risks to treatment, including but not limited to: sprains and strains, fractures, disc injuries, dislocations, general aggravations of inflammatory conditions, allergic responses, and strokes. Our office specializes in low-force techniques and conservative approaches to minimize risks and maximize results. The doctor will discuss with you the nature and purpose of chiropractic adjustments and other procedures. The doctor will perform an exam in order to minimize any risk of care, however, I do not expect the doctor to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor to exercise professional judgment during the course of the procedure which the doctor feels at the time, based upon facts as then known, is in my best interest. Finally, I understand that the chiropractors and staff at Southern Oregon Sports and Spine give no guarantee or assurance as to the results of his/her procedures.

Other treatment options for your condition may include: self-administered, over-the-counter analgesics; medical care which could include prescription medicine, physical therapy, surgery or hospitalization. Our office does not recommend ignoring symptoms. There are risks if you do not get treated.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the recommended procedures. I intend this document to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or guardian's signature: _____ Date: _____