Southern Oregon Sports and Spine

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987 Siskiyou Blvd. Ashland, OR 97520
(541)482-0625; Fax (541)482-3364

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.

_____ _____

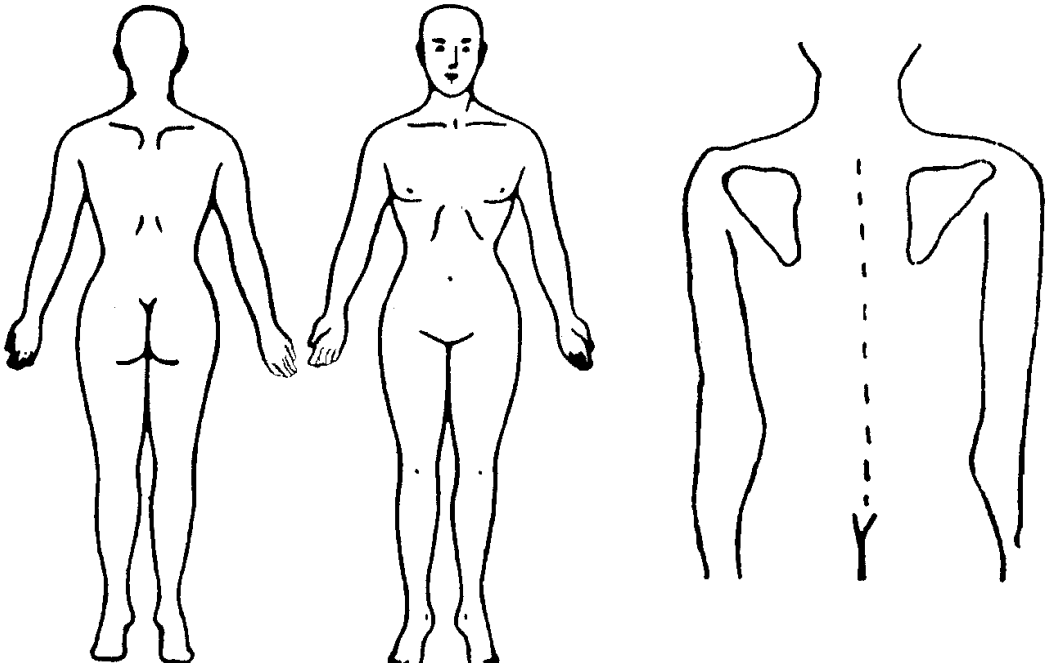
Signature
*Date*_____ _____
Parent (if minor) *Date*

NAME _____ DATE _____

PATIENT PAIN PROFILE for Southern Oregon Sports and Spine 987 Siskiyou Blvd., Ashland, OR 97520

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
   b. sharp
   c. shooting
   d. burning
   e. deep
   f. radiating
   g. numbness or tingling
   h. other _____

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 _____

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

CONSTITUTIONAL NONE
Fatigue
Fever

MUSCULOSKELETAL NONE
Osteoporosis
Arthritis
Joint Pain
Other: _____

NEUROLOGICAL NONE
Anxiety
Headaches
Dizziness/Vertigo
Memory Loss
Numbness
Seizures
Other: _____

EYES NONE
Glasses/Contacts
Double Vision
Cataracts
Other:_____

EAR, NOSE, THROAT NONE
Difficulty Hearing
Ringing in Ears
Sinus Trouble
Other: _____

ALLERGIES/IMMUNE NONE
Hives/Eczema
Hay Fever
Other:_____

CARDIOVASCULAR NONE
Chest Pain
Shortness of Breath
Stroke
Murmur
Palpitations
Heart Disease
High Cholesterol
High Blood Pressure
Fainting Spells
Dizziness
Difficulty Laying Flat
Swelling Ankles
Other: _____

RESPIRATORY NONE
Asthma
Cough
Coughing Blood
Wheezing
Chills
Other: _____

ENDOCRINE NONE
Diabetes
Weight Loss/Gain
Loss of Hair
Heat/Cold Intolerance
Other: _____

MENTAL NONE
Depression
Alcohol/Substance Abuse
Other: _____

GASTROINTESTINAL NONE
Heartburn/Reflux
Nausea/Vomiting
Constipation
Diarrhea
Black/Bloody Stools
Changes In BM
Abdominal Pain
Jaundice (yellowish skin)
Other: _____

HEMATOLOGY/LYMPH NONE
Bruise Easy
Gums Bleed Easy
Enlarged Glands
Other: _____

SKIN NONE
Rash/Sores
Itching/Burning
Dryness
Other: _____

GENITOURINARY NONE
Burning/Frequency
Blood In Urine
Incontinence
Other:_____

OTHER KNOWN CONDITIONS
_____
_____
_____
_____
_____

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES AS BEST YOU CAN)
_____
_____
_____

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

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

Marc Heller, DC, PC
Matt Terreri, DC
Rachel Knight, 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. Rachel Knight, 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

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your or get more information about it by contacting the office manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature	Date	Time

Printed name	Relationship (parent, legal guardian, personal Representative)

This form will be retained in your medical record.

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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 ; RACHEL KNIGHT, 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., Rachel Knight, D.C.
987 Siskiyou Blvd, Ashland, OR 97520 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., Rachel Knight, 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: _____

Marc Heller, DC, PC
Matt Terreri, DC
Rachel Knight, DC

Southern Oregon SPORTS & SPINE

Serving the Valley Since 1980

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NON – COVERED SERVICE PATIENT CONSENT FORM

I, _____ (patient name),

understand that certain services and/or supplies listed below may not be considered eligible for benefits such as services and/or supplies that may be determined to be not medically necessary, non-covered or investigational.

by _____ (health insurer).

The fee for non-covered services (e.g. extra spinal, cold laser, manual therapy, cranial work or exercise) will be $30.00 per unit.

I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain the services and/or supplies listed above, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

Please inform us 24 hours in advance of cancelling an appointment. If you do not notify us to cancel, we reserve the right to charge $35 for the missed appointment.

Patient or Legal Guardian Signature:

_____

Witness Signature:

_____