Welcome

Today's Date: ____/____/____

Patient Name: ________________________________ What you preferred to be called?: ____________
LAST FIRST MI

Birthdate: ____/____/____ Age: ___ ❑Male ❑Female E-Mail Address: ____________________

Mailing Address: ____________________ City, State, Zip: ____________________

Home Phone #: ____________ Work Phone #: ____________ Cell Phone # ____________

Employer: ____________________ Employer's Address: ____________________

Referred by: ____________________ Do you have children? ❑No ❑Yes How Many: ______

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

Account Information
Person ultimately responsible for account:

Name: ____________________ Relation: __________ Work Phone: ____________

Billing Address: ____________________ City, State, Zip: ____________________

D.L #: ____________________ **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 if offered at this office.
INITIALS

1. Is today's problem caused by:
- ☐ Auto Accident
- ☐ Workman's Compensation
- ☐ 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
- ☐ Dull
- ☐ Diffuse
- ☐ Achy
- ☐ Burning
- ☐ Shooting
- ☐ Stiff
- ☐ Numb
- ☐ Tingly
- ☐ Sharp with motion
- ☐ Shooting with motion
- ☐ Stabbing with motion
- ☐ Electric like with motion
- ☐ Other: ____________

5. How are your symptoms changing with time?
- ☐ Getting Worse
- ☐ Staying the Same
- ☐ Getting Better

6. Using a pain scale from 0-10, how would you rate your problem?
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable)

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
- ☐ ER physician
- ☐ Massage Therapist
- ☐ Neurologist
- ☐ Orthopedist
- ☐ Physical Therapist
- ☐ Primary Care Physician
- ☐ Other: ____________
- ☐ No one

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: ____________

Temp: ____________

Patient Name:

10. How long have you had this problem (date)? ____________________

11. How do you think your problem began? ____________________

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

13. What aggravates your condition? ____________________

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

15. What is your: Height__________ **Weight** __________ **Occupation**____________________

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

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

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

19. 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.

Past	Present	Past	Present	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/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV / AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		**For Females Only**
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Birth Control Pills
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Hormonal Replacement
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Pregnancy
□	□ Arthritis	□	□ Hepatitis		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular In-coordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:	□	□ Fibromyalgia		

20. List all prescription medications you are taking: ____________________

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

22. List all surgical procedures you have had and approximate dates: ____________________

Kevin Ross D.C. Brandy Careri D.C. 1117 Pacific Blvd. SE - Albany, OR 97321 | **541.928.1010**

Patient Name:

23. 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

24. What activities do you do outside of work? Activities or hobbies: ______________________

25. Have you ever been hospitalized? □ No □ Yes If yes, why ______________________

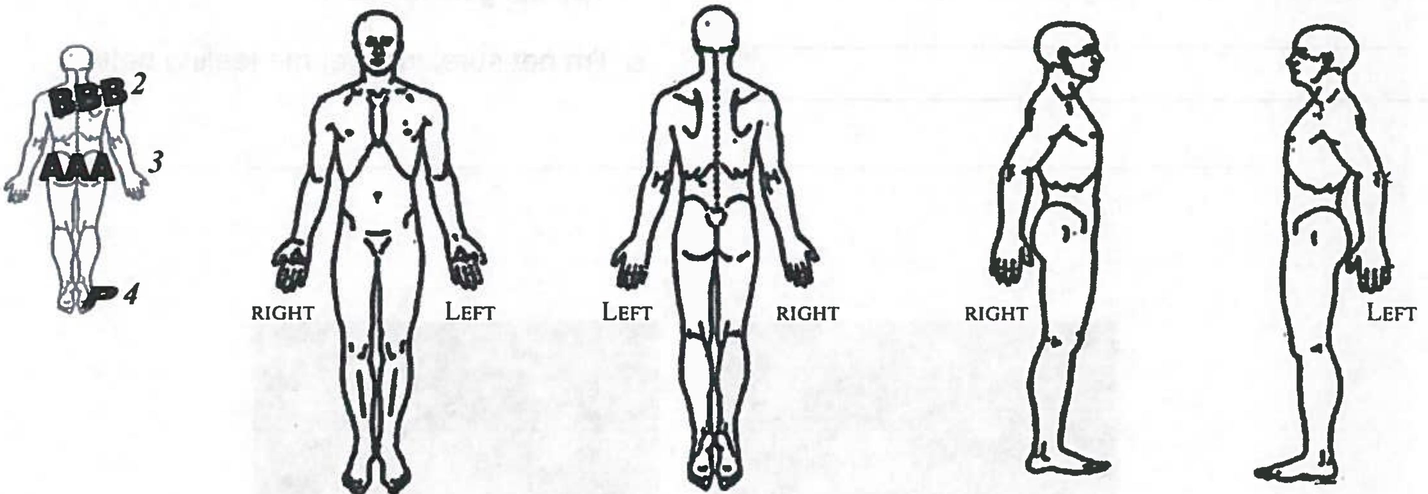
26. Have you seen a Chiropractor before? □ No □ Yes If yes, how long ago? ______________________

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

27. Have you had significant past trauma? □ No □ Yes ______________________

28. 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



- 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:** ______________________

Advanced CHIROPRACTIC

Welcome

Patient Name:

How did you hear of our office?

- ☐ Online Search (which search engine?): ________________
- ☐ Recommended by a friend (name): ________________
- ☐ Referred by my insurance company: ________________
- ☐ Referred by a health care provider: ________________

I was *referred* by one of the Doctors:

- ☐ Dr. Kevin Ross
- ☐ Dr. Brandy Careri

I *found* Advanced Chiropractic in another way:

____

____

We want to serve you best!

What services would you like to have discussed with you? (Mark any or all that apply):

- ☐ Chiropractic adjustments by hand
- ☐ Chiropractic adjustments with a tool
- ☐ Muscle stimulation
- ☐ Massage therapy
- ☐ Home stretches and exercises
- ☐ Rehab exercise program
- ☐ Neck / back braces
- ☐ Pillows
- ☐ Supplements
- ☐ Topical gels for pain

- ☐ I'm not sure, just get me feeling better!!

Kevin Ross, D.C.

Brandy Careri, D.C.

Advanced Chiropractic Physician Team

~Where Caring Happens~

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