



REDMOND  
WELLNESS  
& CHIROPRACTIC

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clinic@drherrin.com

Today's Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**If you are completing this form for somebody else....**

What is your name? \_\_\_\_\_ Relationship to the patient? \_\_\_\_\_

A phone number to reach you at? \_\_\_\_\_ Contact you in case of emergency? Y N

Will you be attending appointments with the patient? Yes No Sometimes Maybe/Not sure

Full Name: \_\_\_\_\_ Gender: M F Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Status: Full time Part time Do not work Unemployed Unable to work Retired

**In case of emergency**, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary phone number: \_\_\_\_\_ Secondary number: \_\_\_\_\_

**How did you hear about RW&C?** Newspaper Magazine TV Friend/Family Healthcare Provider Other

Who may we thank for referring you? \_\_\_\_\_

**Patient Health Information (PHI) Privacy Agreement**

1. The patient understands and agrees to allow Redmond Wellness & Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. Redmond Wellness & Chiropractic staff has been trained in the area of protecting PHI. Precautions have been taken to assure patient records are not available to those who do not need them.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
5. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
6. Patients have the right to file a formal complaint with Redmond Wellness & Chiropractic about any possible violations of these policies and procedures.

**I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

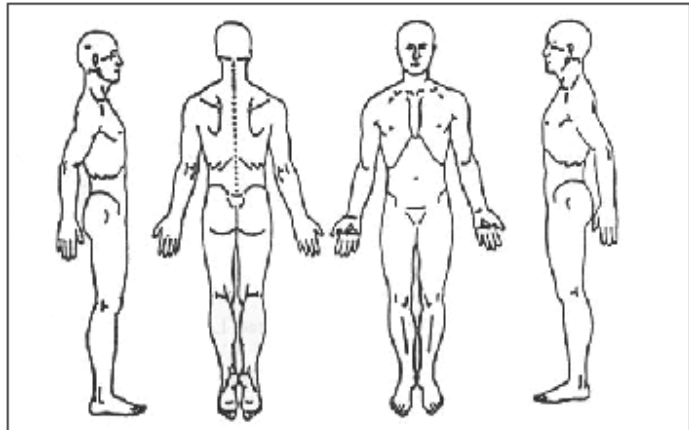
Patient Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

List the three symptoms you most want to see improve with your treatment and care at RW&C:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please mark the diagram to the right with the abbreviations listed below to indicate your symptoms.

- SS = Spasms
- SH = Shooting Pain
- SP = Sharp Pain
- DP = Dull Pain
- ST = Stiffness
- T = Tingling
- N = Numbness



When did this problem originally occur (can be approximate)? \_\_\_\_\_ How did it originally occur?

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Is this the first time you've sought treatment for this symptom?  Yes  No

Who else has treated you for this symptom? \_\_\_\_\_

What other methods/treatments have you tried **that have helped**?  Medication (Rx OTC)  Surgery  
 Physical Therapy  Rest  Lifestyle Change  Chiropractic Care  Massage Therapy  Acupuncture  
 Other \_\_\_\_\_  Other \_\_\_\_\_

What other methods/treatments have you tried **that have NOT helped**?  Medication (Rx OTC)  Surgery  
 Physical Therapy  Rest  Lifestyle Change  Chiropractic Care  Massage Therapy  Acupuncture  
 Other \_\_\_\_\_  Other \_\_\_\_\_

How long ago did this episode of symptoms begin? \_\_\_\_\_

Recently, have your symptoms been...  Same  Better  Gradually worse  Much worse  Intermittent

How often are you experiencing your symptom(s)?  Constantly  A few hours at a time  A few minutes at a time  
 Briefly  Only with certain activities  Randomly

Does anything help to relieve your symptom(s)?  Ice  Heat  Stretching  Pressure/Massage  Rest  Exercise  
 Sitting  Standing  Lying down  Medication  Other \_\_\_\_\_

What makes your symptoms worse?  Sitting  Standing  Walking  Lying  Bending  Stretching  Lifting  
 Twisting  Reaching out  Other \_\_\_\_\_

What activities, if any, is your pain interfering with?  Work/School  Sleep  Recreation  Daily Routines  
 Other \_\_\_\_\_

Looking back on the **last three days**, how would you rate your pain on a scale of 1-10, where 1 is no pain and 10 is intolerable pain? 1 2 3 4 5 6 7 8 9 10

Using the same scale, how would you rate your pain **right now**? 1 2 3 4 5 6 7 8 9 10

## Patient Health History

Please check all of the **conditions/symptoms** that apply to you (P=Past, C=Current)

- |  |  |  |  |
|--|--|--|--|
| P/C<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Tingling Hands/Feet<br><input type="checkbox"/> Elbow/Hand Pain<br><input type="checkbox"/> Diabetes Type 1<br><input type="checkbox"/> Diabetes Type 2<br><input type="checkbox"/> Thyroid Problems | P/C<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Paralysis<br><input type="checkbox"/> Ankle/Foot Pain<br><input type="checkbox"/> Joint Stiffness<br><input type="checkbox"/> Excessive Thirst<br><input type="checkbox"/> Nausea/Vomiting<br><input type="checkbox"/> Migraines | P/C<br><input type="checkbox"/> Fatigue<br><input type="checkbox"/> Abdominal Pains<br><input type="checkbox"/> Neck Pain<br><input type="checkbox"/> Insomnia<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Walking Problems<br><input type="checkbox"/> Knee Pain<br><input type="checkbox"/> Hormone Problems<br><input type="checkbox"/> High Cholesterol | P/C<br><input type="checkbox"/> Hip Pain<br><input type="checkbox"/> Low Back Pain<br><input type="checkbox"/> Herniated Disc<br><input type="checkbox"/> Degenerative Disc Disease<br><input type="checkbox"/> Shoulder Pain<br><input type="checkbox"/> Weak Muscles<br><input type="checkbox"/> Bowel/Bladder Dysfunction |
|--|--|--|--|

<b>Current medications, vitamins, supplements, treatments, etc.</b>	Taking for:

Please list all **allergies** and/or sensitivities you have: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List and describe any **serious accidents** (please give approximate dates) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List and describe any **surgeries and hospital stays** (please give approximate dates) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all **broken bones and sprains**: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a primary care physician?  No  Yes (Who? \_\_\_\_\_)

Do you see a doctor regularly?  No  Only when necessary  Yes ( MD/NP  Chiropractor  Naturopath  
 Other \_\_\_\_\_)

Do you see any specialist regularly? If so, for what? \_\_\_\_\_

\_\_\_\_\_

## Family Health History

Please check all of the **conditions/symptoms** that apply to you or your family (P = Personal, F = Family)

P/F <input type="checkbox"/> <input type="checkbox"/> Alcoholism <input type="checkbox"/> <input type="checkbox"/> Anemia <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Cold sores <input type="checkbox"/> <input type="checkbox"/> Deep vein thrombosis <input type="checkbox"/> <input type="checkbox"/> Detached retina <input type="checkbox"/> <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> <input type="checkbox"/> Diabetes Type 2	P/F <input type="checkbox"/> <input type="checkbox"/> Eczema <input type="checkbox"/> <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> Goiter <input type="checkbox"/> <input type="checkbox"/> Gout <input type="checkbox"/> <input type="checkbox"/> Heart Disease <input type="checkbox"/> <input type="checkbox"/> High Cholesterol <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS	P/F <input type="checkbox"/> <input type="checkbox"/> Miscarriage(s) <input type="checkbox"/> <input type="checkbox"/> Mumps <input type="checkbox"/> <input type="checkbox"/> Pleurisy <input type="checkbox"/> <input type="checkbox"/> Pneumonia <input type="checkbox"/> <input type="checkbox"/> Polio <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Tumor(s)	P/F <input type="checkbox"/> <input type="checkbox"/> Ulcer(s) <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/> Other: _____
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## Patient Lifestyle

### Activity level at work:

- Heavy Labor  
  Light Labor  
  Walking/Moving  
 Mostly Standing  
  Mostly Sitting  
  Driving  
 Don't work

### Activity level at home:

- Very Active  
  Regular Exercise  
  Intermediate Exercise  
  Recreational Activities  
  Housework/Childrearing  
 Sedentary  
  Immobile

### Stress level at work:

- Extremely High  
  High  
  Some/Moderate  
 Low  
  Rare/None

### Stress level at home:

- Extremely High  
  High  
  Some/Moderate  
 Low  
  Rare/None

Do you maintain a regular **sleep** schedule?  Yes    No    I have young children    I have a changing work schedule

Meals per Day: \_\_\_\_\_ Do you often snack between meals?  Yes    No

How many **servings** do you consume per day of: Fruits/Vegetables? \_\_\_\_\_ Proteins? \_\_\_\_\_ Carbohydrates? \_\_\_\_\_ Dairy? \_\_\_\_\_ Sugars? \_\_\_\_\_ Water (8oz)? \_\_\_\_\_

Do you consume **alcohol**?  Never    Rarely    Occasionally    Every Week    Every Day/Almost Every Day  
 I have a history of alcohol addiction/abuse

When you consume alcohol, how many drinks do you typically have? \_\_\_\_\_ servings    I don't know

Do you use tobacco products?  Never    Rarely    Occasionally    Every Week    Every Day/Almost Every Day    I am in a tobacco cessation program    I have a history of tobacco addiction    I would like to quit consuming tobacco

## Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including massage therapy and various modes of physical therapy by Dr. David Herrin, DC, and his Chiropractic Assistant(s). I have had the opportunity to discuss with the doctor and/or with clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments offered at Redmond Wellness & Chiropractic. Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment, which include but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Financial Policy

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to your health and well-being. Payment is due at the time of treatment. We accept several methods of payment including cash, check, major credit/debit cards (Visa, MasterCard, Discover), and CareCredit (a medical financing option, ask for details and/or an application).

If, for any reason, you have an account in arrears with our office and we are not able to establish a repayment plan, your account will be sent to collections. This is used only as a last resort by this office. If this option must be used, as 20% fee will be added to your account to help with the fees incurred by this office. We will always work with you to get your account paid in full.

**Missed Appointment Policy:** Your appointment time is reserved for you; please arrive on time to maximize your time with the doctor. Please give 24 hour notice if you are unable to keep your appointment, or a \$25 fee may be applied to your account.

If you have questions on your suggested treatment plan or the available payment options, please do not hesitate to ask. We are here to help you!

**Please sign your initials in the box next to the category that applies to you.** This indicates that you have read and clearly understand your situation and obligations.

**General (Non-insurance):** Fees are to be paid at the time of service, unless special arrangements have been made in advance. After your initial new patient office visit, your typical charges will be based on the treatment plan you accept from the doctor's recommendations. This may include an adjustment, therapies, exam fees, and/or other supportive care. Refer to our Menu of Care for details

**Treatment Packages:** Purchase a bundle of treatments and save! Some packages may be used as a family plan also. You must have a signed Treatment Package Agreement on file to use this option. See our Menu of Care or ask us for details.

**Group/Private Insurance:** RWC will verify your insurance coverage as a courtesy, but as your insurance company cannot guarantee payments based on quoting your benefits, neither can we. You are responsible for ALL deductibles, co-payments, coinsurances, and non-covered therapies at the time of service. When necessary the fee will be estimated and you will be billed/refunded the difference when your insurance issues payment. All payments must be made in accordance with your agreement with your insurance provider and our agreement with your insurance provider (if any exists); this includes you being personally responsible for payment should you reach your benefit maximum or should any lapse in coverage occur.

**Medicare:** This office has contracted with Medicare to accept assignment. This means we bill Medicare for your adjustment fee. Medicare pays for adjustment fees only, not therapies and exams. You are responsible for deductibles and co-payments according to Medicare guidelines, and any other service you accept as part of your necessary treatment. If you have a secondary insurance, Medicare will forward your claim under the Medigap policy.

**Worker's Compensation:** Under the Oregon Worker's Compensation Law, Chiropractic services are covered initially for 18 visits or 60 days of care. Beyond these limits, you will need a referral and treatment plan from a medical doctor (MD) to return to our office for additional treatment. The insurance company has 45 days to accept or deny a claim. If your claim is denied, you will become personally responsible for the payment of your care

**Auto Accident/Personal Injuries:** It is our policy to bill your auto/personal insurance directly regardless of who was at fault in the accident/injury. If there is a third party involved, they will reimburse your insurance company when the claim is settled. Through your insurance policy, you are entitled to coverage for up to one year, after which you may need an attorney to arbitrate. If we have not received payment within 90 days, your claim is denied, or you are being treated past your one year PIP benefit date, you will be expected to pay for your fees in full.

**I have read and understand the office policies and fees of this office. I understand that I am ultimately responsible for payment of my care and any fees incurred.**

Patient (or Guardian) Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

Print Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_