INITIAL HEALTH STATUS

CARING RELIEF FOR:
Headaches
Back and neck pain
Shoulder and arm pain
Knee and leg pain
Whiplash

FOR YOUR COMFORT AND CONVENIENCE
Available weekends
Same-day appointments
Insurance accepted and filed
Flexible payment plans
Major credit cards accepted

RESSLER CHIROPRACTIC INC.

Where your relief is our first concern, but your health is our primary purpose.

Name_________________________________ ☐ Male ☐ Female Home Phone________________________

Address (No P.O. Box)______________________________ City____________________ Zip_____________

The below box is our primary means of communication, please complete as legibly as possible.

Email Address______________________________________ Cell Phone______________________________

*Social Security # - - *Required for HIPAA Portal Communication Carrier/Provider (att, sprint, Verizon…) ____________

Age______ Date of Birth___________________ Marital: M S How many children?___________________

Occupation___________________________________ Employer______________________________________

Employer Address___________________________________ City____________________ Zip_____________

Work Phone________________________________

Name of Spouse____________________________________ Occupation______________________________

Employer____ Work Phone________________________________

Name of Parents (if under 18 yrs.)____

Benefits desired from seeking care in our office (check all that apply):

☐ Maintenance or Supportive Care
☐ Correction of Your Condition
☐ Pain Relief

Chief complaint(s): ☐ Neck ☐ Upper back ☐ Mid back ☐ Low back
☐ Shoulder/arm ☐ Hip/leg ☐ Headaches ☐ Other________________________

Date problem began ___________________

Other doctors seen for this condition ____

Is this condition due to a: ☐ Work injury? ☐ Auto accident? ☐ Slip and fall? ☐ N/A

How problem began ____

Financial Responsibility

- I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.
- I further understand that Ressler Chiropractic Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to Ressler Chiropractic Inc. will be credited to my account upon receipt.
- I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.
- I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature___________________________________ Date_________________________

HEALTH HISTORY QUESTIONNAIRE

Name: ____

What is your chief reason for being here? ____

If there is a specific condition; how long has it been occurring? _______________________________

Do you have any relatives with similar problems? ☐No ☐Yes, Who? ___________________________

List any practitioners seen for this condition: ____

Have you had similar problems before? ____

Have you been treated for any health condition by a physician in the last year? ☐No ☐Yes

If yes, describe: ____

List diagnosis and type of treatments so far: ____

What do you feel is causing any health problems you may have? ______________________________

Please indicate **any** occurrence of the following and give details and dates:

Accidents/injuries: ____

Fractures: ____

Hospitalizations/Surgeries :____

Have you lost any days of work recently? ☐No ☐Yes Dates: ___________________________

What is your Height: __________ Weight: ______________ Blood Pressure: _______/_______ (last reading)

Current complaint (how you feel today): 0 1 2 3 4 5 6 7 8 9 10

No Pain ... Unbearable Pain

How often are your symptoms present?

(Occasional) ☐10 - 25% ☐26-50% ☐51-75% ☐76 - 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

0 1 2 3 4 5 6 7 8 9 10

No interference ... Can't Do Anything

Please check all of the following that apply to you:

- ☐Recent Fever
- ☐Diabetes
- ☐High Blood Pressure
- ☐Heart Attack
- ☐Stroke
- ☐Corticosteroid Use (cortisone, prednisone, etc.)
- ☐Taking Birth Control Pills
- ☐Dizziness/Fainting
- ☐Numbness in Groin/Buttocks
- ☐Cancer/Tumor
- ☐Osteoporosis
- ☐Epilepsy/Seizures
- ☐Prostate Problems
- ☐Menstrual Problems
- ☐Urinary Problems
- ☐Currently Pregnant, # weeks ________
- ☐Abnormal Weight Gain or Loss
- ☐Marked Morning Pain/Stiffness
- ☐Pain Unrelieved by Position or Rest
- ☐Pain at Night
- ☐Visual Disturbances
- ☐Surgeries
- ☐Medications (list to right)
- ☐Other Health Problems (explain to right)

Family History:

- ☐Cancer
- ☐Diabetes
- ☐High Blood Pressure
- ☐Heart Problems/Stroke
- ☐Rheumatoid Arthritis

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature ____ Date _________________________

INJURY QUESTIONNAIRE

PATIENT NAME: ________________________________

HISTORY OF NON-AUTO INJURY?
If your injury was not caused by an automobile accident, skip to page 2 and make sure you fill page 4.

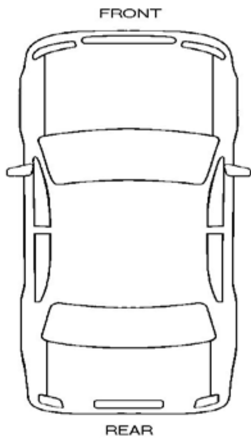
I. EXPLANATION OF ACCIDENT (Please check the appropriate answers)

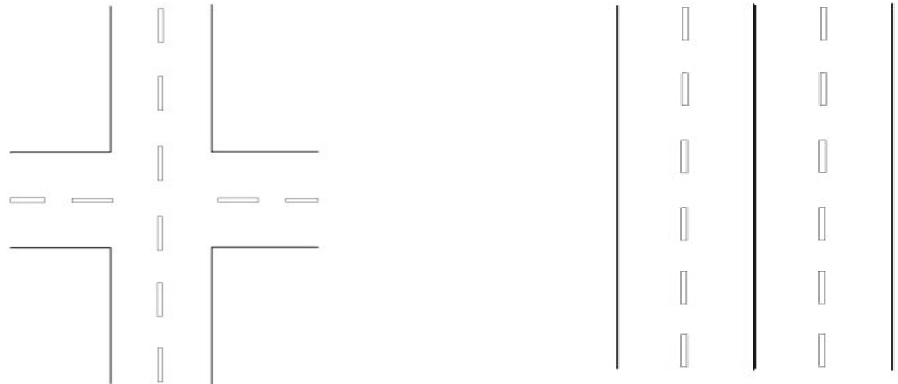
1. DATE OF ACCIDENT: ____________________ TIME OF DAY: ________________
2. YOUR VEHICLE MAKE AND MODEL: ____ YEAR: _________________
3. YOUR SEAT: ☐ Driver ☐ Passenger (If Passenger) ☐ In the front ☐ Back ☐ Middle ☐ Other: ______________
4. OTHER VEHICLE MAKE AND MODEL: ____ YEAR: _________________
5. HOW WAS YOUR VEHICLE STRUCK? IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:

____

____

DRAW THE DAMAGE TO YOUR VEHICLE AND A DEPICTION OF THE ACCIDENT
If filling online: 1. Print form after filling fields 2. Finish drawing 3. Sign form





6. DAMAGE TO YOUR VEHICLE: ☐ Slight ☐ Moderate ☐Severe Estimate: $_____________ ☐ Pictures Attached
7. DAMAGE TO OTHER VEHICLE: ☐ Slight ☐ Moderate ☐Severe
8. WAS YOUR CAR STOPPED AT THE MOMENT OF IMPACT? ☐ No ☐ Yes If Yes WHY? ________________________
9. ROAD CONDITIONS: ☐ Dry and clear ☐ Damp ☐ Wet and rainy ☐ Other ______________________________
10. AT IMPACT WERE YOU: ☐ Unprepared ☐ Holding steering wheel ☐ Braced for impact
    ☐ Stepping hard on brake Looking ☐ R ☐ L ☐ Straight ahead
11. IF TURNED, WERE YOU TURNED AT THE: ☐ Waist ☐ Neck ☐ Both
12. WEARING SEATBELT? ☐ Yes ☐ No
13. USING HEADREST? ☐ Yes ☐ No (steering wheel. Dash, side window…)
14. DID ANY PART OF YOUR BODY STRIKE ANYTHING? ☐ No ☐ Yes What? ________________________________
15. DID YOU LOSE CONSCIOUSNESS? ☐ No ☐ Yes How long? ____
16. HOW DID YOU FEEL IMMEDIATELY AFTER THE INJURY?
    ☐ Shocked ☐ Shaky ☐ Nervous ☐ Scared ☐ Dazed ☐ Confused ☐ Dizzy ☐ Nauseated ☐ Other ___________
17. WERE THE POLICE NOTIFIED? ☐ Yes ☐ No Why not? ____
18. DO YOU HAVE A COPY OF THE POLICE REPORT? ☐ Yes ☐ No

II. EXPLANATION OF YOUR CONDITION

1. DID YOU FEEL PAIN IMMEDIATELY? ☐ Yes ☐ No
   IF YES, WHERE?
   ☐ Head ☐ Neck ☐ Forehead ☐ Upper Back ☐ Middle Back ☐ Lower Back
   ☐ Chest ☐ Rib Cage ☐ Side
   ☐ Eye ☐ Ear ☐ Cheek ☐ Nose ☐ Chin ☐ Mouth/Jaw
   ☐ Shoulder ☐ Arm ☐ Forearm ☐ Elbow ☐ Wrist ☐ Hand/Finger
   ☐ Abdomen ☐ Pelvis
   ☐ Hip ☐ Buttocks ☐ Thigh ☐ Lower Leg ☐ Knee ☐ Knee ☐ Ankle ☐ Foot/Toe

2. HOW LONG AFTER THE INJURY DID IT TAKE TO DEVELOPE PAIN?
   ☐ A few minutes later ☐ An hour Later ☐ A few hours later ☐ That evening ☐ The next morning
   ☐ A couple of days later ☐ A week later ☐ A couple of weeks later ☐ Other: ________________________________
3. DID YOU GO TO THE HOSPITAL? ☐ No ☐ Yes WHICH ONE? ____
   a. IF YES, HOW DID YOU GET THERE? ☐ Ambulance ☐ Drove self ☐ Ride from someone else
   b. WERE X-RAYS, CTs OR MRIs TAKEN? ☐ Yes ☐ No Explain ________________________________
   c. WERE YOU PRESCRIBED MEDICATION? ☐ Yes ☐ No Explain ________________________________
   d. WERE YOU ADMITTED (STAY)? ☐ No ☐ Yes How long? ________________________
4. HAVE YOU BEEN SEEN BY A DOCTOR OUTSIDE A HOSPITAL SINCE THE INJURY? ☐ No ☐ Yes
   IF YES LIST DOCTORS SEEN: ____
   ____
   a. WERE X-RAYS, CTs OR MRIs TAKEN? ☐ No ☐ Yes Explain ________________________
   b. WERE YOU PRESCRIBED MEDICATION? ☐ No ☐ Yes Explain ________________________
5. ARE YOU TAKING OVER THE COUNTER MEDICATION? ☐ No ☐ Yes Explain ______________________
6. DID YOU HAVE ANY PAIN FROM 6 MONTHS PREVIOUS--TO THE INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
7. HAVE YOU EVER HAD ANY SIMILAR SYMPTOMS BEFORE THIS INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
8. HAVE YOU HAD ANY OTHER UNRELATED INJURIES SINCE THE DATE OF THIS INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____

III. CHANGES IN LIFESTYLE DUE TO THIS INJURY

5. HAVE YOU MISSED ANY WORK AS A RESULT OF THIS INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
2. ARE THERE ANY JOB DUTIES YOU CAN'T PERFORM AS A RESULT OF THIS INJURY? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
3. WERE YOU? ☐ At work ☐ Going to work ☐ Leaving work
   IF ANY, EXPLAIN: ____
4. ARE THERE ANY HOME DUTIES OR SPORTS/RECREATION ACTIVITIES YOU CAN'T DO AS A RESULT OF THIS INJURY?
   ☐ No ☐ Yes IF YES, EXPLAIN: ____
5. ARE YOU LOSING SLEEP DUE TO YOUR PRESENT CONDITION? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____
6. HAS YOUR SEXUAL ACTIVITY BEEN AFFECTED DUE TO YOUR PRESENT CONDITION? ☐ No ☐ Yes
   IF YES, EXPLAIN: ____

IV. PLEASE LIST ALL OF YOUR *CURRENT SYMPTOMS*

HEAD
- [ ] Blurred Vision
- [ ] Double Vision
- [ ] Eyes Sensitive to Light
- [ ] Eye Pain
- [ ] Eye Strain
- [ ] Pain Behind the Eyes
- [ ] Hearing Problems
- [ ] Buzzing/Ringing in ears
- [ ] Loss/Change in Smell
- [ ] Loss/Change in Taste
- [ ] Dizziness
- [ ] Equilibrium Problems
- [ ] Face Flushed
- [ ] Pain at Base of Skull
- [ ] Headaches
- [ ] Head Feels Heavy

JAW/TEETH
- [ ] Teeth Missing
- [ ] Loose Teeth
- [ ] Tooth Ache
- [ ] Pain with Chewing
- [ ] Clicking with Chewing
- [ ] Jaw Pain
- [ ] Jaw Locking

NECK
- [ ] Neck Pain
- [ ] Neck Spasm
- [ ] Neck Stiffness
- [ ] Neck Swelling
- [ ] Pinched Nerve in Neck
- [ ] Grinding Sound in Neck

SHOULDER
- [ ] Shoulder pain
- [ ] Shoulder Spasm
- [ ] Shoulder Stiffness
- [ ] Shoulder Swelling
- [ ] Can’t Raise Arms Over Head
- [ ] Pain in Shoulder Joint
- [ ] Pinched Nerve in Shoulder

CHEST
- [ ] Chest Pain
- [ ] Chest Tightness
- [ ] Difficulty Breathing
- [ ] Rapid Heart Beat
- [ ] Palpitation

ARMS/HANDS
- [ ] Pain in Upper Arm
- [ ] Pain in Lower Arm
- [ ] Numbness/Tingling in Arms/Hands
- [ ] Cold Arm/Hand
- [ ] Elbow Pain
- [ ] Elbow Stiffness
- [ ] Elbow Swelling
- [ ] Wrist Pain
- [ ] Wrist Stiffness
- [ ] Wrist Swelling
- [ ] Hand Pain
- [ ] Hand Stiffness
- [ ] Hand Swelling
- [ ] Weakness in Arms
- [ ] Loss of Grip Strength

MIDDLE BACK
- [ ] Mid Back Pain
- [ ] Mid Back Spasm
- [ ] Mid Back Stiffness
- [ ] Mid Back Swelling
- [ ] Pain Between Shoulder Blades

ABDOMEN
- [ ] Pain Across Pelvis
- [ ] Constipation
- [ ] Gas
- [ ] Nausea
- [ ] Stomach Pain

LOW BACK
- [ ] Low Back Pain
- [ ] Low Back Spasm
- [ ] Low Back Stiffness
- [ ] Low Back Swelling
- [ ] Pinched Nerve in Back
- [ ] Flank Pain (under ribs)
- [ ] Tailbone Pain
- [ ] Sacro-Iliac Pain

HIPS
- [ ] Hip pain
- [ ] Hip Spasm
- [ ] Hip Stiffness
- [ ] Hip Swelling
- [ ] Can’t Put Weight on Hip
- [ ] Pain in Hip Joint

LEGS/FEET
- [ ] Pain in Thigh
- [ ] Pain in Lower Leg
- [ ] Numbness/Tingling in Leg/Foot
- [ ] Cold Leg/Foot
- [ ] Knee Pain
- [ ] Knee Stiffness
- [ ] Knee Swelling
- [ ] Ankle Pain
- [ ] Ankle Stiffness
- [ ] Ankle Swelling
- [ ] Foot Pain
- [ ] Foot Stiffness
- [ ] Foot Swelling
- [ ] Weakness in Legs
- [ ] Difficulty Standing/Walking

NERVOUS SYSTEM
- [ ] Anxiety
- [ ] Irritability/Angry
- [ ] Nervous/Tense
- [ ] Stressed
- [ ] Depressed
- [ ] Mental Dullness
- [ ] Memory Loss
- [ ] Forgetful
- [ ] Inability to Concentrate
- [ ] Tremors/Shaky
- [ ] Insomnia

OTHER
- [ ] Loss of Appetite
- [ ] Excessive Thirst
- [ ] Excessive Hunger
- [ ] Extreme Fatigue
- [ ] Abnormal Urination
- [ ] Abnormal Bowel Changes
- [ ] Vomiting
- [ ] Runny Nose
- [ ] Nose Bleeds
- [ ] Blood in Urine or Stools
- [ ] Tender Breasts
- [ ] Change in Menses
- [ ] Change in Libido
- [ ] Impotence
- [ ] Hemorrhoids
- [ ] Swollen Glands
- [ ] Contusions
- [ ] Abrasions
- [ ] Lacerations

OTHER:

V. HISTORY OF NON-AUTO RELATED INJURY

(skip and sign and date below if auto accident)

1. DATE OF INJURY: ______________________ TIME OF DAY: __________________

2. LOCATION OF INJURY: ____

3. WITNESSES? ☐ No ☐ Yes

4. IN YOUR OWN WORDS, PLEASE DESCRIBE THE INJURY:

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____ ____________________________________

PATIENT SIGNATURE DATE