CLEAR FORM

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

Have you reported this injury to your employer? Yes No

Have you been in contact with the Insurance Adjuster? Yes No

Have you been given authorization to see a chiropractor? Yes No

Did the adjuster have you pick someone from a MPN list? Yes No

What is the name, phone, fax and address of your current employer?

Employer Name: _____

Phone: _____ Fax: _____ Address: _____

City: _____ Zip: _____

What is the name, phone, fax and address of your Employers Insurance?

Insurance Co. Name: _____ Adjusters Name: _____

Phone: _____ Fax: _____ Address: _____

City: _____ Zip: _____

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

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 _____

PATIENT NAME _____

I. COMPANY AND JOB INFORMATION

TYPE OF BUSINESS: _____ YOUR JOB: _____

DATE INJURED: _____ HOUR: _____ LAST DATE WORKED: _____

ARE YOU OFF WORK BECAUSE OF THIS INJURY? ❑ YES ❑ NO

HAVE YOU PREVIOUSLY HAD A WORKER'S COMPENSATION INJURY? ❑ YES ❑ NO

WAS THIS ACCIDENT REPORTED TO YOUR EMPLOYER? ❑ YES ❑ NO

NAME OF PERSON YOU REPORTED THE ACCIDENT TO: _____

DID YOUR EMPLOYER SEND YOU TO OUR OFFICE? ❑ YES ❑ NO

DOES YOUR EMPLOYER KNOW YOU ARE SEEKING CARE HERE? ❑ YES ❑ NO

ADDRESS INJURED AT: _____ CITY: _____ ZIP: _____

LENGTH OF TIME WORKED AT YOUR COMPANY PRIOR TO INJURY: _____

TYPE OF WORK BEING DONE AT THE TIME OF INJURY: _____

II. INJURY INFORMATION

IN YOUR OWN WORDS DESCRIBE THE ACCIDENT:

_____

_____

_____

_____

_____

_____

III. PREVIOUS CARE

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS ACCIDENT? ❑ YES ❑ NO

IF YES, LIST DR. NAME & ADDRESS: _____

WHAT TYPE OF TREATMENT DID YOU RECEIVE? _____

HOW LONG WERE YOU TREATED BY THIS DOCTOR? _____

ARE YOU: ❑ IMPROVING ❑ UNCHANGED ❑ GETTING WORSE

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: (INCLUDING NON PRESCRIPTION)

_____

DO THESE MEDICINES HELP? ❑ YES ❑ NO ❑ DON'T KNOW

HAVE YOU HAD PHYSICAL THERAPY? ❑ YES ❑ NO

IF YES, HOW OFTEN? _____

PATIENT NAME _____

IV. PAST HISTORY

PRIOR TO THIS ACCIDENT HAVE YOU EVER HAD ANY OF THE SYMPTOMS SIMILAR TO WHAT YOU HAVE NOW? ❑ YES ❑ NO IF YES, DESCRIBE IN DETAIL: _____

WERE THESE SIMILAR SYMPTOMS THE RESULT OF A PREVIOUS ACCIDENT? ❑ YES ❑ NO

IF YES, PROVIDE DETAILS OF THE ACCIDENT: _____

DESCRIBE ANY OTHER SERIOUS ACCIDENTS WHICH REQUIRED MEDICAL CARE: _____

DESCRIBE ANY SERIOUS ILLNESSES THAT REQUIRED HOSPITALIZATION: _____

HAVE YOU HAD ANY SURGERIES? ❑ YES ❑ NO

IF YES, LIST TYPE OF SURGERY AND DATE PERFORMED _____

HAVE YOU EVER SUFFERED FROM A NERVOUS OR MENTAL CONDITION? ❑ YES ❑ NO

HAVE YOU EVER RECEIVED PSYCHIATRIC CARE? ❑ YES ❑ NO

HAVE YOU RECEIVED A MEDICAL DISCHARGE FROM THE ARMED SERVICES? ❑ YES ❑ NO

V. CURRENT STATUS

HAVE YOU RETURNED TO WORK SINCE THIS ACCIDENT? ❑ YES ❑ NO

IF YOU HAVE RETURNED TO WORK, LIST THE DAY YOU RETURNED: _____

SINCE RETURNING TO WORK HAVE YOU MISSED ANY DAY DUE TO THE EFFECTS OF THIS INJURY?

❑ YES ❑ NO IF YES, LIST DATES: _____

PATIENT NAME _____

VI. CHIEF COMPLAINTS

1. PLEASE LIST YOUR COMPLAINTS IN ORDER OF SEVERITY FROM WORST TO LEAST.

1. _____ HOW LONG? _____
2. _____ HOW LONG? _____
3. _____ HOW LONG? _____
4. _____ HOW LONG? _____
5. _____ HOW LONG? _____

2. HAVE YOU HAD TO CURTAIL ANY SPORTS OR RECREATION ACTIVITIES? ❑ NO ❑ YES

IF YES, WHICH ONES? _____

_____

3. HAVE YOU HAD TO CURTAIL ANY HOUSEHOLD ACTIVITIES? ❑ NO ❑ YES

IF YES, WHICH ONES? _____

4. HAVE YOU HAD TO CURTAIL ANY OTHER ACTIVITIES? ❑ NO ❑ YES

IF YES, WHICH ONES? _____

5. WHAT TYPE OF BED DO YOU SLEEP ON?

❑ Regular Box Spring ❑ Waterbed ❑ Futon ❑ Platform

HOW OLD IS YOUR MATTRESS? _____

6. USUAL SLEEPING POSITION: ❑ Side ❑ Back ❑ Stomach

7. TYPE OF PILLOW USED? _____ HOW OLD IS YOUR PILLOW? _____

8. ARE YOU LOSING SLEEP DUE TO YOUR PRESENT CONDITION? ❑ NO ❑ YES

Please continue with job description below

PATIENT NAME _____

VII. JOB DESCRIPTION

DEFINITIONS:
"OCCASIONALLY" means 33% of your work day,
"FREQUENTLY" means 34% - 66%, and
"CONTINUOUSLY" means 67% - 100% of your work day

IN A TYPICAL 8 HOUR DAY, I (Check the box that applies)

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
BEND/STOOP	❒	❒	❒	❒
SQUAT	❒	❒	❒	❒
CRAWL	❒	❒	❒	❒
CLIMB	❒	❒	❒	❒
REACH SHOULDERLEVEL	❒	❒	❒	❒
LIFT	❒	❒ #lbs_____	❒ #lbs _____	❒
CROUCH	❒	❒	❒	❒
KNEEL	❒	❒	❒	❒
BALANCING	❒	❒	❒	❒
PUSHING/PULLING	❒	❒	❒	❒

DO YOU HAVE TO BEND OVER WHILE DOING ANY LIFTING ❒ Yes ❒ No

DO YOU USE YOUR FEET FOR REPETITIVE MOTIONS SUCH AS OPERATING FOOT CONTROLS?

❒ Yes ❒ No DESCRIBE: _____

DO YOU USE YOUR HANDS FOR REPETITIVE NOTIONS SUCH AS:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
RIGHT HAND	❒	❒	❒
LEFT HAND	❒	❒	❒

ARE YOU REQUIRED TO WORK ON UNPROTECTED HEIGHTS? ❒ Yes ❒ No

ARE YOU REQUIRED TO BE AROUND MOVING MACHINERY? ☐ Yes ☐ No

DESCRIBE _____

ARE YOU EXPOSED TO MARKED CHANGES IN TEMPERATURE AND HUMIDITY? ❒ Yes ❒ No

DESCRIBE _____

ARE YOU REQUIRED TO DRIVE AUTOMOTIVE EQUIPMENT? ❒ Yes ❒ No

DESCRIBE _____

ARE YOU EXPOSED TO DUST, FUMES, AND/OR GRASS? ☐ Yes ❒ No

PLEASE ADD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE ABOUT YOUR INJURY OR YOUR ACCIDENT:

I CERTIFY THAT THIS IS A TRUE ACCOUNT OF MY WORK RELATED INJURY/ACCIDENT,

PATIENT SIGNATURE _____ DATE _____

PRINT FORM E-MAIL FORM