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?_____

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

What is your Height: _____ Weight: _____ Blood Pressure: _____/_____ (last reading)

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.

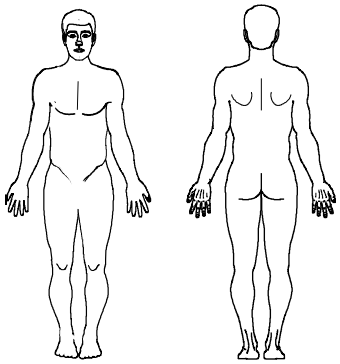
Patient's Signature_____ Date_____

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. *-->When you come in.*



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began_____

How Problem Began

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) ☐ 0 – 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?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

PRINT FORM E-MAIL FORM