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

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 _____

Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)	2. Federal tax ID(TIN) of entity in box #1
Ressler Chiropractic Inc.	451603105

3. Name and credentials of the individual performing the service(s): David C. Ressler

1 MD/DO [X] 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1	5. NPI of entity in box #1	6. Phone number
	1740574847	650-583-4080

7. Address of the billing provider or facility indicated in box #1	8. City	9. State	10. Zip code
1133 El Camino Real, Ste 7	South San Francisco	CA	94080

Provider Completes This Section:

Date you want *THIS* submission to begin:

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1° 2° 3° 4°

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score

Neck Index | DASH | (other FOM)

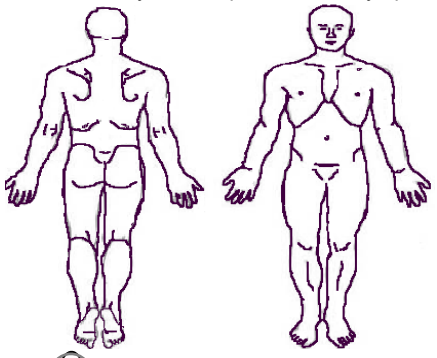
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain ● 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain ● 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?

1 Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

6. How is your condition changing, since care began at *this* facility?

0 **N/A — This is the initial visit** 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better

7. In general, would you say your overall health right now is...

1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Patient Signature: X _____ **Date:** _____

PRINT FORM E-MAIL FORM