Welcome

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Accident Information

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

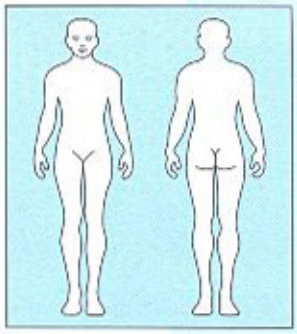
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Rheumatoid	☐ Yes ☐ No		
		Liver Disease	☐ Yes ☐ No				

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

Allergies

_____
_____
_____
_____
_____

Vitamins/Herbs/Minerals

_____
_____
_____
_____
_____

PERSONAL INJURY QUESTIONNAIRE

Home Phone ( ) _____

Name _____ Work Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status _____ Sex _____ S/S # _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____ Adjuster's Name _____

Name on Policy (if other than self) _____ Claim # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Ins. Co. Phone # _____ Ext. _____

ATTORNEY

Name _____ Phone ( ) _____

Address _____ City _____ State _____ Zip _____

Were there any witnesses? ☐ Yes ☐ No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ☐ North ☐ East ☐ South ☐ West
   on (name of street) _____
5. What direction was other vehicle headed? ☐ North ☐ East ☐ South ☐ West
   on (name of street) _____
6. Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side
7. Approximate speed of your car _____ mph Other car _____ mph
8. Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____
9. What position was your head at time of impact? Looking straight ahead _____ Turned Left _____ Turned Right _____
10. Were police notified? ☐ Yes ☐ No
11. In your own words, please describe accident: _____

_____

_____

_____

12. Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If yes, please describe in detail:

_____

_____

_____

13. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____

14. Where were you taken after the CURRENT accident? _____

15. Have you been treated by another doctor since the accident? ☐ Yes ☐ No If yes, please list doctor's name and address:

_____

What type of treatment did you receive? (ex: MRI, X-Ray, Meds) _____

_____

16. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

17. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above _____

18. What are your PRESENT complaints and symptoms? _____

_____

_____

19. Have you ever been involved in an accident before? ☐ Yes ☐ No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

_____

20. Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No If yes, please describe:

21. Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No If yes, please describe:

_____

_____

22. Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, please complete this question:

a. Last Day Worked: _____

b. Type of Employment: _____

c. Present Salary: _____

d. Are you being compensated for time lost from work? ☐ Yes ☐ No If yes, please state type of compensation you are receiving: _____

23. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe, in detail:

_____

_____

_____

24. Other pertinent information: _____

25. Please list all medications you are taking? _____

26. List any types of surgeries and dates? _____

27. Liquor consumed on a weekly basis? _____

28. Do you smoke? _____ If yes, how much per day? _____

29. Any significant family medical history _____

_____ _____

DATE PATIENT'S SIGNATURE

OVIEDO INJURY & WELLNESS CENTER

DR. MARTIN RESSLER, III
870 Clark Street
Suite 1040
Oviedo, FL 32765
Telephone: (407) 977-5005
Fax: (407) 366-3327

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (Please Print) **Date**

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.