Geise Chiropractic L.L.C.

New Patient Work Related Accident

Today's Date ________________________

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name___________________________________ **Preferred to be called**______________________________

Last Name __________________________________ **Middle Name** ____________________**Suffix** __________

Address 1 ____

Address 2 ____

City____ **State**_____________ **Zip Code** ______________________

Primary Phone ______________________________**Secondary Phone** _________________________________

Mobile Phone ____

Home Email _________________________________ **Work Email** __________________________________

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth [/ /] **Age** _______ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

SSN __________________________________ **Marital Status** *(check one)*❑ Single ❑ Married ❑ Other

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_________	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

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Continued …

Name ____

Verification Question *(choose only one question by circling the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen Question: (minimum 6 letters)________________________________

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
No interest *Very Interested*

Current medications, including dosage if known.
If there are no current medications, check here: ❑

1) ______________________ **5)** ______________________

2) ______________________ **6)** ______________________

3) ______________________ **7)** ______________________

4) ______________________ **8)** ______________________

For Women: Are you taking Birth Control? Y N Are you Pregnant? Y N How Long? _______ Nursing? ____

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ______________________ **3)** ______________________

2) ______________________ **4)** ______________________

Briefly list your main health problems: ______________________________
____

Has any doctor diagnosed you with Hypertension/High Blood Pressure presently?❑ Yes❑ No If yes, describe:
____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ______________________________

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Health History:
List any fractures you have ever had: ______________________________
List any previous surgeries : ______________________________
List any past serious accidents with dates: ______________________________
Family Health History: ______________________________
Medical Doctor: ______________________ Phone # ______________

To be performed by clinic staff: **Height:** ________inches **Weight:** _______ pounds

BP: __________ **Pulse:** __________

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Name: ________________________

Date and Time of accident: __________________________ Was this accident directly related to work? Y N

Name and Address where injury occurred: ____

____

Briefly describe the events that occurred just before and during the accident: _____________________________

____

____

Did you seek any other medical attention? Y N If so, explain: _____________________________________

Was anyone else present during the accident? Y N Did you report this to your employer? Y N

What recommendations did your employer make just after the accident? _______________________________

Has this type of accident happened to you before? Y N
To the best of your knowledge, has this accident occurred in your workplace before? Y N When?
____

In general: Is your job physically stressful? Y N Is your job mentally stressful? Y N
Have you changed jobs in the last year? Y N Is your workplace noisy? Y N

Claim # ________________

MCO Name and Address: __________________________________ Phone #: _____________________

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours in your normal work day? _____

Please indicate your daily job duties and activities which you are asked to perform:
☐ Standing ☐ Sitting ☐ Walking ☐ Lifting ☐ Stooping ☐ Work with arms above head
☐ Twisting ☐ Crawling ☐ Bending ☐ Typing ☐ Driving ☐ Operating Equipment
☐ Other _________________________________

What positions can you work in with minimum physical effort and for how long? __________________________

Prior to the injury were capable of working on an equal basis with others your age? Y N

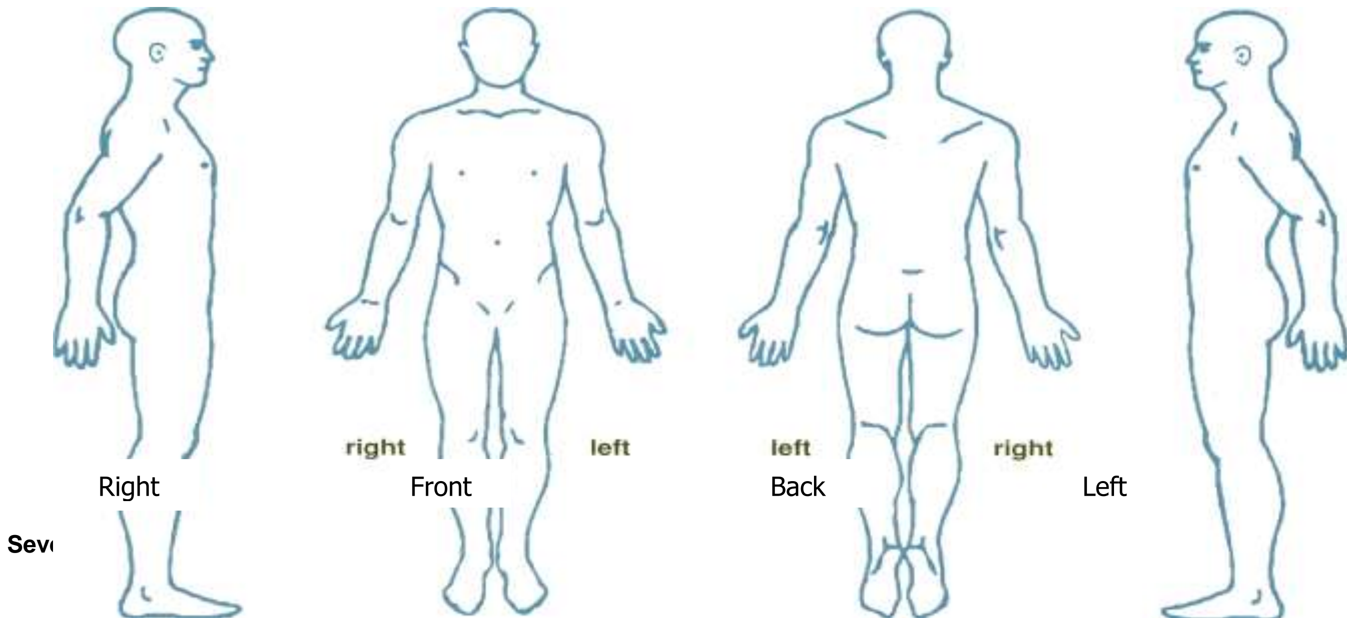
Do you work with others that can help you with any heavy lifting? Y N

Is there any light duty work you could request while in recovery? Y N

Please mark area(s) of injury or discomfort. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme).

Description→	Dull	Sharp	Throbbing	Burning	Aching	Tingling	Cramping	Stabbing	Numbness
Symbol→	**DDD**	**PPP**	**TTT**	**BBB**	**AAA**	**GGG**	**CCC**	**SSS**	**NNN**

◯ ***Circle any area of pain not represented by a symbol.***



Mild-----------------Mild to Moderate-----------------Moderate-----------------Moderate to Severe-----------------Severe

1 2 3 4 5 6 7 8 9 10

How Frequent is your pain in a day: (circle the percentage)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Aggravating Factors

☐Sitting ☐Standing ☐Walking ☐Bending ☐Stooping ☐Lifting
☐Sleeping ☐Sneezing ☐Coughing ☐Straining ☐Reaching ☐Twisting
☐Looking up ☐Looking down ☐Movement ☐Rest ☐Lying Supine ☐Driving
☐Typing ☐Scooping ☐Household chores ☐Exercise ☐Stair Stepping
☐Other Activities _________________

Relieving Factors

☐Sitting ☐Standing ☐Knees Bent up ☐ Support
☐No Movement ☐Movement ☐Heat ☐Ice ☐Analgesic Topical
☐Ibuprofen ☐Medication ☐Rest ☐Stretching/Exercise ☐Adjustments

Name__________________

Patient Employer: ______________________ Occupation/Duties: ________________________________

Spouse's Name: ______________________________ Phone: ____________________

Emergency Contact: _______________________ Relation: _________________ Phone# ____________

______ **I hereby authorize assignment of my insurance rights and benefits directly to the provider Geise**
(initial)

Chiropractic, LLC. for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. I have agreed to pay in a current manner any balance of said professional service charges over and above.

______ **I authorize release of information, report of my diagnosis, treatment, prognosis and recommendations,**
(initial)

to all my INSURANCE COMPANIES AND ATTORNEY'S (if applicable), I also understand if the insurance company deems a service to be non-covered I am responsible for payment of those services (i.e. braces, exercise bands, Orthotics, vitamins, and nutritional supplements, etc.)

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

***Signature: ____ Date: ____/____/_____**

☐ **Adult Patient** ☐ **Parent or Guardian** ☐ **Spouse**