P.I.

MIDDLEBURG HTS CHIROPRACTIC OFFICE
DR. ROY A. GOLSCH, D.C.

PATIENT REGISTRATION
PLEASE PRINT- WRITTEN INFORMATION WILL NOT BE ACCEPTED

TODAY'S DATE:_____ HOME PHONE NUMBER: ( )_____

PATIENT'S FULL NAME:_____ BIRTHDATE:_____/_____/____ AGE:_____

PATIENT'S ADDRESS:_____
STREET CITY STATE ZIP

SEX: MALE( ) FEMALE( ) SOCIAL SECURITY #:_____ DRIVER LICENSE#_____

MARTIAL STATUS: ( ) SINGLE ( ) MARRIED ( ) WIDOW ( ) DIVORCED
RACE: ( ) AMERICAN INDIAN/ALASKAN NATIVE ( ) ASIAN ( ) AFRICAN AMERICAN ( ) CAUCASIAN ( ) OTHER ( )DECLINED
ETHNICITY: ( ) HISPANIC ( ) NON-HISPANIC ( ) DECLINED

EMPLOYER:_____ EMPLOYER PHONE # ( )_____

SPOUSE'S NAME:_____ DATE OF BIRTH:____/____/_____ SOCIAL SECURITY#_____

MEDICARE#_____ MEDICAID#_____ OTHER_____

PRIMARY INSURANCE:_____ POLICY HOLDER:_____

SECONDARY INSURANCE:_____ POLICY HOLDER:_____

IN CASE OF EMERGENCY PLEASE NOTIFY:_____ PHONE:_____

RELATIONSHIP_____ ADDRESS:_____

INJURY INFORMATION

DATE OF INJURY:____/_____/_____ RELATED TO ACCIDENT : NO YES AUTO (PLEASE CIRCLE ONE)

STATE WHERE ACCIDENT OCURRED: _____

NATURE OF THE ACCIDENT: ( ) INJURED AT HOME ( ) INJURED AT SCHOOL ( ) INJURED DURING ( ) MOTORCYCLE ACCIDENT ( ) RECREATION ( ) WORK INJURY/NON-COLLISION ( ) WORK INJURY/SELF EMPLOYED ( ) WORK INJURY/COLLISION

ATTORNEY NAME:_____ ADDRESS:_____

HISTORY OF INJURY: IN YOUR OWN WORDS, PLEASE BRIEFLY DESCRIBE YOUR INJURY:_____

PREVIOUS CONDITIONS AND TREATMENT: IN YOUR OWN WORDS, PLEASE LIST ANY PREVIOUS MEDICAL CONDITIONS AND TREATMENT:_____

ASSIGNMENT AND RELEASE

I, UNDERSIGNED HAVE INSURANCE COVERAGE WITH THE ABOVE MENTIONED INSURANCE CARRIER(S) AND ASSIGN DIRECTLY TO **DR. ROY A. GOLSCH, D.C.**, ALL MEDICAL 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 HEREBY AUTHORIZE **DR. ROY A. GOLSCH, D.C.**, TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.**NO INFORMATION PERTAINING TO YOUR CARE WILL BE RELEASED TO ANY OTHER ENTITY WITHOUT YOUR SPECIFIC AUTHORIZTION.

SIGNATURE:_____ DATE:_____

Employment, ADL, and Recreation Information

Patient Name: _____ **Case:** _____ **Date:** _____ **Dr:** _____

Occupation/Job Title: _____ **Work:** _____ **hrs / day or week**

Description of Work: _____

Job Classification: ☐ **Sedentary** (<5lbs) ☐ **Light** (5-20lbs) ☐ **Moderate** (20-50lbs) ☐ **Heavy** (>50 lbs)

Lifting Frequency: ☐ **Constant** (67-100%/day) ☐ **Frequent** (33-66%/day) ☐ **Occasional** (0-32%/day)

Lifting Postures: ☐ **with Arms** ☐ **High Near** ☐ **from Knee** ☐ **Off Posture** ☐ **from Torso**

Work Activity Postures: (hrs/day)

☐ **bending:** _____h/d ☐ **climbing:** _____h/d ☐ **kneeling:** _____h/d ☐ **pulling:** _____h/d ☐ **pushing:** _____h/d
☐ **reaching:** _____h/d ☐ **sitting:** _____h/d ☐ **standing:** _____h/d ☐ **twisting:** _____h/d ☐ **walking:** _____h/d

Repetitive Activities: (hrs/day)

☐ **assembly/fine manipulation:** _____h/d ☐ **computer use/typing:** _____ h/d ☐ **grasping:** _____ h/d
☐ **hand tool use:** _____ h/d ☐ **operation of machinery controls:** _____ h/d ☐ **phone use:** _____h/d

Condition's Effect On Job Performance: ☐ **No Effect** ☐ **Mild** Painful (Can do) ☐ **Mod** Painful (limited ability)
☐ **Mod/Sev** Limited Duty ☐ **Sev** No Limited Duty ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

Auto Accident Form

Patient Name _____ Today's Date ____/____/_____

Please mark your involvement in the Auto Accident: ☐ Pedestrian ☐ Driver ☐ Passenger

What are your current symptoms? ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Date of Accident ____/_____/_____

Patient was located: ☐ Driver ☐ Passenger- middle front ☐ Passenger- right front
☐ Passenger- left rear ☐ Passenger- middle rear ☐ Passenger -right rear

Patient Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Second Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Third Vehicle Type: ☐ Compact ☐ Mid-size ☐ Full-Size ☐ SUV ☐ Pick-up ☐ Motorcycle

Road Conditions: ☐ Clear ☐ Dark ☐ Dry ☐ Foggy ☐ Icy ☐ Wet

Road Type: ☐ Asphalt ☐ Concrete ☐ Dirt ☐ Gravel

Were you aware the accident was going to occur? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Did your airbag deploy? ☐ Yes ☐ No

Does your car have a head rest? ☐ Yes ☐ No

What position was the head rest in? ☐ Up ☐ Middle ☐ Down

Patient's Head Position: ☐ Looking Straight Ahead ☐ Left Level ☐ Left Up ☐ Left Down
☐ Right Level ☐ Right Up ☐ Right Down ☐ Looking Up ☐ Looking Down

Accident Details

Was your car braking? ☐ Yes ☐ No Was your car moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the second vehicle braking? ☐ Yes ☐ No Was the second vehicle moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Was the third vehicle braking? ☐ Yes ☐ No Was the third vehicle moving? ☐ Yes ☐ No
If yes, how fast? (mph) ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ >70

Collision Details

First Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left
☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top

Second Impact: ☐ hit by other vehicle ☐ hit other vehicle ☐ hit by object ☐ hit object
Impact Location: ☐ front ☐ front-right ☐ front-left ☐ left
☐ right ☐ right-rear ☐ left-rear ☐ rear ☐ top

Collision Results

Body was thrown: ☐ Forward ☐ Backward ☐ Left ☐ Right ☐ Can't Remember

Head Hit: ☐ airbag ☐ front windshield ☐ rearview mirror ☐ steering wheel
☐ dashboard ☐ back of the front seat ☐ side window/door ☐ another person's body ☐ headrest

Chest Hit: ☐ airbag ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ side window/door ☐ another person's body

Shoulders Hit: ☐ shoulder harness ☐ side window/door ☐ back of front seat ☐ another person's body

Knees Hit: ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ door panel ☐ center console ☐ another person's body

Hips Hit: ☐ steering wheel ☐ dashboard ☐ back of the front seat
☐ door panel ☐ center console ☐ another person's body

Vehicle Damage

Patient Vehicle: ☐ totaled ☐ significant damage ☐ light damage ☐ no damage
Second Vehicle: ☐ totaled ☐ significant damage ☐ light damage ☐ no damage
Third Vehicle: ☐ totaled ☐ significant damage ☐ light damage ☐ no damage

Hospitalized

Were you hospitalized? ☐ Yes ☐ No. If yes, please answer the questions below.

When were you hospitalized? ☐ immediately ☐ later same day ☐ next day ☐ date _____

How were you transported to the hospital? ☐ ambulance ☐ life flight ☐ private transportation

What did the hospital recommend? ☐ no instructions ☐ see this clinic ☐ see DC
☐ see own doctor ☐ see orthopedist ☐ see neurologist ☐ prescription medication
☐ other: _____

Did you have any xrays taken? ☐ Yes ☐ No
If yes, what areas? _____

DOCTOR/ PATIENT AGREEMENT
PERSONAL INJURY

At the patient's request, this office will bill any and all other insurance companies.

HOWEVER

1. We will not be liable for the insurance company's actions on payment of the claims.

2. The patient is still responsible (or the parent if the patient is a minor) for 100% full payment of our services 30 days after discharge from treatment.

I, _____, hereby agree to the above
(Name – printed)

conditions, as it was my request for this office to bill my insurance company(s).

_____ _____
(Signature) (Date)

Roy A. Golsch, D.C.
15350 E. Bagley Rd.
Middleburg Hts., OH 44130
(440) 886-4990 Fax: (440) 886-1288

MIDDLEBURG HTS. CHIROPRACTIC OFFICE, INC.

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Office: (440) 886-4990 • Fax: (440) 886-1288

DR. ROY A. GOLSCH, *CHIROPRACTIC PHYSICIAN*

ASSIGNMENT AND RELEASE

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_____ _____

SIGNATURE **DATE**