Patient Information

Today's Date: _______________ Date of Birth: _______________ Age: ______ M___ F___

First Name: _______________________ Last Name: ____________________________ MI: ___

Address: ____

City: _______________ State: _____ Zip Code: ____________ SSN: ___________________________

Home Phone: _________________ Work Phone: _________________ Cell Phone: _______________

Email Address: ____

Occupation: __________________ Employer: ____

Employer Address: ____

Employer City/State/Zip Code: ____

Insurance Carrier: __________________________ Carrier Phone #: ____________________________

Carrier Address/City/State/Zip: ____

Policy #: ____________________ Group #: ____________________ Claim #: _________________

Additional Insurance (Supplemental, from Spouse/Parent, etc) Carrier: ____________________________

Add'l Carrier Address/City/State/Zip: ____

Add'l Carrier Phone: ____________________ Add'l Carrier Policy #: ________________________

Physician: ________________________________ Phone: _____________________________________

Physician: ________________________________ Phone: _____________________________________

Referred By: ____

Attorney Name & Phone: ____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.

Signed: ____ Date: ____________________

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Dr. Ryan M. Thomas, Chiropractor, for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signed: ____ Date: ____________________

Consent to Treatment for a MINOR: I hereby authorize Dr. Thomas to treat and direct treatment for my child who is under the age of eighteen (18) years of age.

Child's Name: ____________________ Parent's Signature: ____________________ Date: __________

Name____ **Date**______________

Workers' Compensation

1. When did your injury occur? ____
2. Type of Business & Job Occupation? ____
3. Describe the injury/accident in your own words:

   ____

   ____

   ____

4. Did you report this incident to your employer? Yes ☐ No ☐
5. Name of the person incident was reported to: _________________________________
6. If lifting, how much weight was involved? __________________________________
7. If lifting, what position were you in? _______________________________________
8. What, if any, kind of equipment was involved? ______________________________
9. Was this incident caused by failure of equipment or product? Yes ☐ No ☐

   If yes, what type of failure? ____
10. If struck by an object, what was it? ____

    Where were you struck? ____
11. If you fell, how far did you fall? _______________ Inside ☐ Outside ☐
12. What body parts have been injured? (please circle all that apply)

    Back Head Neck Shoulder Hand Hip Knee Foot
13. What were the conditions at the time of your accident? (Example: icy, wet, slippery floor, object in the way, etc.) ____
14. Can you perform physical work in any capacity? Yes ☐ No ☐
15. Can you perform physical work in a modified duty capacity? Yes ☐ No ☐
16. Can you work in a SITTING position with some degree of walking and/or standing?

    Yes ☐ No ☐
17. What position can you work in a PART-TIME capacity and for how long?

    ____

Name____ Date______________

Work Description & Duties

1. Please describe your job: ____

2. In a typical 8 hour workday, How many hours to you…? (circle number of hours for each)
   Sit 0 1 2 3 4 5 6 7 8 hours
   Stand 0 1 2 3 4 5 6 7 8 hours
   Walk 0 1 2 3 4 5 6 7 8 hours

3. On the job, I perform the following activities: (mark all that apply with a 'X')

In terms of an 8 hour workday ***occasionally*** means 0-33%, ***frequently*** means 34-66%, and ***continuously*** means 67-100%.

	Not at all	Occasionally	Frequently	Continuously
Bend/Stoop				
Squat				
Crawl				
Climb				
Reach above				
Crouch				
Kneel				
Push/Pull				
Balance				

4. Relate your **BEFORE** injury capacity (mark 'B') and your **AFTER** injury capacity (mark 'A') when performing the following activities:

	Normal	Limited	Difficult	Painful
Walking				
Sitting				
Standing				
Bending				
Stooping				
Lifting				
Pushing				
Pulling				
Climbing				
Reaching				
Gripping				
Kneeling				
Balancing				

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Gresham, Oregon 97030 • (503) 491-0388 • *fax* (503) 491-0784

Name____ Date______________

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to Dr. Ryan M. Thomas' office. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand and agree that all services rendered to me are ultimately my responsibility and I am financially responsible for any balance due. I authorize the doctor's office to release any information required to process my claim. I agree to pay all collection costs and attorney fees incurred by me, up to the balance of my account if not paid as agreed upon.

Additionally, I certify that the information give above by me is true and accurate to the best of my recollection.

Patient's signature______________________________________ Date____________________

Do not write below this line.

NOTES:____

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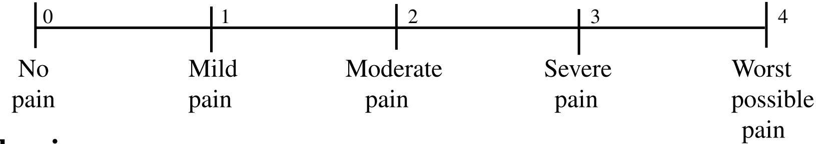
Functional Rating Index

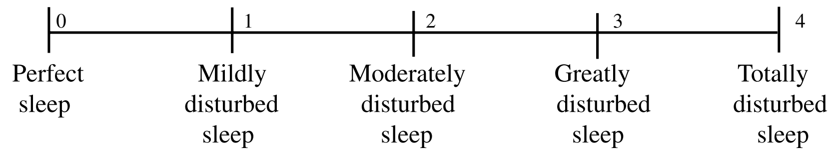
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

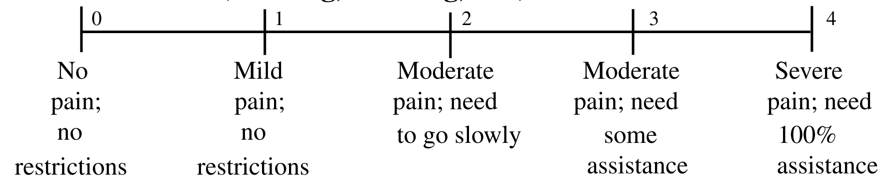
1. Pain Intensity



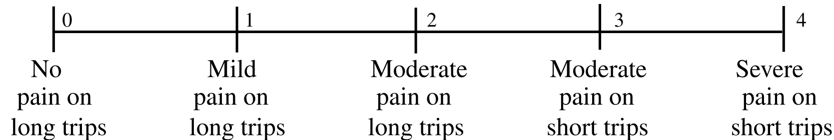
2. Sleeping



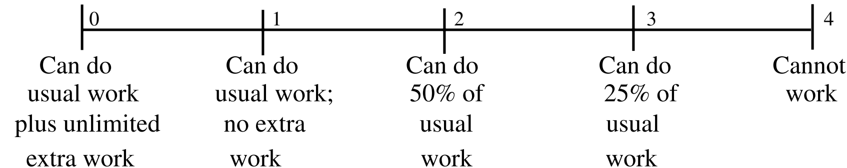
3. Personal Care (washing, dressing, etc.)



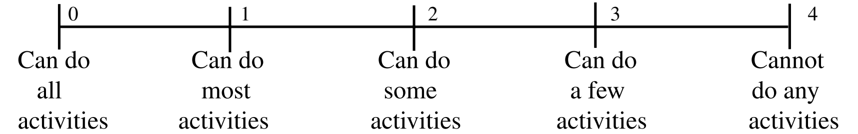
4. Travel (driving, etc.)



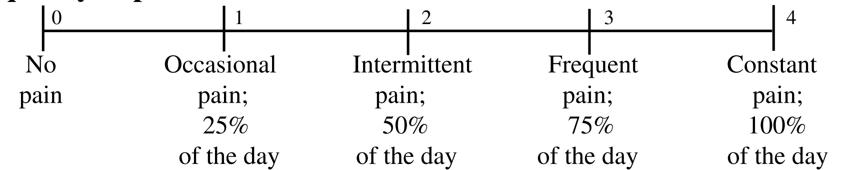
5. Work



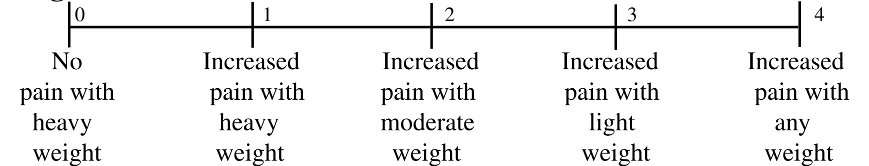
6. Recreation



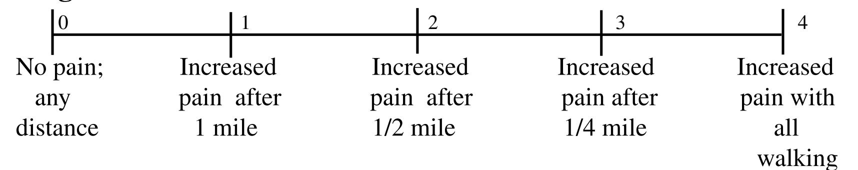
7. Frequency of pain



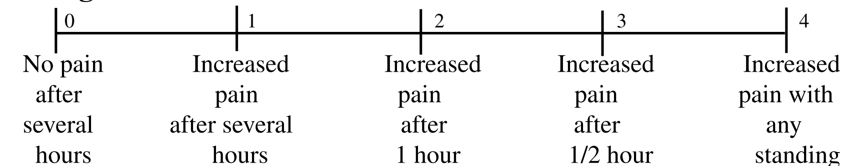
8. Lifting



9. Walking



10. Standing



Name ______________________________
PRINTED

Total Score ________

____
Signature

____
Date

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