**ROBERT P. SEILER INVOICE**

**PLEASE PRINT LEGIBLY!**

**Patient:** Last Name: _____ First Name: _____

Address: _____

City, State, Zip: _____ _____ _____

Date of Birth: ____/____/____ Social Security: _____/_____/_____ Gender: _____

Patient Status: New Patient _____ Established _____ Evaluation Only _____

Pt Phone: _____ Pt Email: _____

**Policy Holder:** if not Patient: Last Name: _____ First Name: _____

Address: _____

Date of Birth: _____/_____/_____ Social Security: _____/_____/_____ Gender: __

City, State, Zip: _____ _____ _____

Relation to Policy Holder: Self: _____ Spouse: _____ Child: _____ Other: _____

**Auto Insurance Name:** _____

Claim #: _____ DOL: _____

Adjustor's Name: _____ Adj's Ph: _____

Adj's Fax: _____ Adj's Email: _____

Adj's Address: _____

**Representing Law Firm:** _____

Attorney's Last Name: _____ First Name: _____

Address: _____

Fax: _____ Ph: _____

Send Bills & Clinicals to: Legal Assistant or Attorney

Best Email Address: _____

- **Patient Signature:** _____ Date: ____/____/____

Holistic Chiropractic & Wellness
Dr. Bob Seiler, Chiropractic Physician
150 S 600 E, Suite 6C, Salt Lake City 84102
801-230-0166

## PATIENT INFORMATION

Name:_____ Date:_____

What You Prefer To Be Called: _____ Sex: [ ] M [ ] F Marital Status: [ ] M [ ] S [ ] D [ ] W

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile:_____ Social Security #:_____

Age:_____ Birthdate:_____ Emergency Contact:_____

Address:_____City:_____State:_____ Phone:_____

Email:_____ May we email you our wellness newsletter? [ ] Y [ ] N

Who may we thank for your first visit? Referred By:_____ OR [ ] Website [ ] Google [ ] Other

Occupation:_____ Employer:_____

Work Address:_____ Work Number:_____

Significant Other's Name:_____ Do you have children? [ ] Y [ ] N Ages:_____

## MEDICAL HISTORY AND SYMPTOM / PAIN INFORMATION

*(Additional room provided to answer questions on the back of this form)*

A. Reason for today's visit: [ ] work [ ] auto [ ] sports/competition [ ] trauma [ ] stress [ ] anxiety [ ] chronic [ ] other

B. Explain what happened:_____->

C. Please describe the pain intensity and its location on the included "Pain Diagram" page.

D. When did this condition begin? ___/___/___ Is it getting worse? [ ] Y [ ] N [ ] Constant [ ] Comes & Goes

E. Is this condition interfering with your: [ ] work [ ] sleep [ ] daily routine [ ] relationships Please explain _____->

F. Have you had this or similar conditions in the past? [ ] Y [ ] N Please explain_____->

G. Have you ever been treated by a Medical Physician for this condition? [ ] Y [ ] N If so, where_____->

H. Have you ever been treated by a Chiropractic Physician? [ ] Y [ ] N If so, for what_____->

I. Please list any falls, slips, concussions, or accidents you may have had with dates:_____->

J. Family Health History (genetics, your environment, epigenetics):_____->

K. The feet are the foundation of your body. Are you now wearing? [ ] heel lifts [ ] sole lifts [ ] inner soles

[ ] arch supports [ ] custom-made orthotics

## SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS

[ ] High Blood Pressure
[ ] Cholesterol
[ ] Thyroid Imbalance
[ ] Insulin Resistance/Diabetes
[ ] Headaches: Migraine, Tension
[ ] Fibromyalgia
[ ] [ ] Weight gain/loss
[ ] Stress, Anxiety, Depression
[ ] Nightmares
[ ] Trauma: Physical/Emotional
[ ] Loss of Family Member/Friend
[ ] Insomnia
[ ] Mood Swings
[ ] Joint Pain
[ ] Posture
[ ] Fallen-arches
[ ] Extensive Alcohol/Drug Use

A.

B.

C.

D.

E.

F.

G.

H.

I.

J.

K.

Name:_____ Health History Intake Form Date:_____

Email: _____ Phone: _____

What are your health goals?

☐ Remove Pain
☐ Gain More Energy/Stamina
☐ Restore Health/Reduce Illness
☐ Achieve Optimal Wellness

What are your top 3 health complaints?

1)_____
2)_____
3)_____

| Question | Y N | Patient Comment | Practitioner Comment |
|---|---|---|---|
| Are you on a particular diet or currently restricting certain foods? | Y N | | |
| Do certain foods upset your stomach or cause constipation, IBS, or headaches? | Y N | | |
| Do you have certain food cravings? | Y N | | |
| Do you get shaky or anxious between meals? | Y N | | |
| Do you drink **less** than half your body weight in water oz daily? (ex: if you weigh 150 lbs, 75 oz would be your daily water intake) | Y N | | |
| Do you drink soda, sports, or energy drinks? | Y N | | |
| Do you chew gum, drink diet drinks or consume sugar-free foods? | Y N | | |
| Have you ever been unconscious, had a concussion, whiplash, closed head injury? | Y N | | |
| Do you get muscle cramps, "charley horses", or eye twitches? | Y N | | |
| Do you frequently use Tylenol, Ibuprofen, or other pain relief medications? (How many milligrams? How often?) | Y N | | |
| Have you taken fish oil & had difficulty keeping it down? | Y N | | |
| Do you have indigestion, belching, gas or bloating? | Y N | | |
| Do you typically go **more** than 24 hours **without** a bowel movement? | Y N | | |
| Have you had any organs surgically removed or medically altered? (appendix, gallbladder, etc.) | Y N | | |
| Have you gained more than 15 lbs in the past year? | Y N | | |
| Do you grind your teeth while you sleep? | Y N | | |
| Do you have trouble falling or staying asleep? | Y N | | |
| Have you had an illness that you have not fully recovered from? | Y N | | |

**Do you have a health diagnosis or are you concerned with any of the following:**

☐ High Blood Pressure
☐ Cholesterol
☐ Insulin Resistance (Diabetes)
☐ Thyroid Imbalance
☐ Arthritis
☐ Fibromialgia
☐ Cardiovascular
☐ Migraines/Headaches
☐ Stress
☐ Other_____

**Please list all medications, supplements, and herbs that you a currently taking:**_____

_____
_____
_____
_____
_____

**Is there anything else you think I should be aware of:** _____

_____
_____
_____
_____

# AUTO / WORK RELATED ACCIDENT

one

two

## ABOUT YOU

Today's Date: ___/___/___ File #: _____

Name: _____

two b

## WORK RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.

Was your accident directly related to your work?
❑ Yes ❑ No

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

Give the address where accident occurred: (if other than employer's address) _____

Was anyone else present during your accident?
❑ Yes ❑ No

Did you report your accident to your employer?
❑ Yes ❑ No

What recommendations did your employer make just after your accident? _____

Has this type of accident happened to you before?
❑ Yes ❑ No

To the best of your knowledge, has this accident occurred in your workplace before? ..... ❑ Yes ❑ No

In general:

Is your job physically stressful? ..... ❑ Yes ❑ No
Is your job mentally stressful? ..... ❑ Yes ❑ No
Is your workplace noisy? ..... ❑ Yes ❑ No
Have you changed jobs in the last year? ❑ Yes ❑ No

## AUTO RELATED ACCIDEN

Date & Time of Accident: _____ ❑ a.m. ❑ p.

Were you the: ❑ Driver ❑ Front Passenger ❑ Rear Passenger

If a traffic violation was issued, to whom was it issued?

Number of people in accident vehicle? _____

Did the police come to the accident site? . . ❑ Yes ❑

Was a police report filed? ..... ❑ Yes ❑

Were there any witnesses? ..... ❑ Yes ❑

Were you wearing your seat belt? ..... ❑ Yes ❑

Was this vehicle equipped with airbags? . ❑ Yes ❑

If yes, did it/they inflate? ..... ❑ Yes ❑

In relation to the base of your skull, where was the headrest? ..... ❑ Above ❑ Below ❑ At base of s

What did your vehicle impact? ❑ Another vehicle ❑ Ot

If other, explain: _____

Did any part of your body strike anything in the vehicle? ❑ Yes ❑

If yes, please describe: _____

Make & model of the vehicle you were occupying?

Name of the location/street on which you were traveli

In which direction were you headed? ❑N ❑S ❑E

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:
❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Otl

During impact, were you facing: ❑ Right ❑ Left ❑ Forv

Were you ❑ aware or ❑ surprised by the impact?

If accident vehicle made impact with another vehicle.
Make and model of that other vehicle? _____

Direction other vehicle was headed? ❑N ❑S ❑E

Speed of the other vehicle? _____

In your words, please describe the accident: _____

PLEASE CONTINUE ON B

## three AFTER INJURY

Did accident render you unconscious? ..... ❑ Yes ❑ No

If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No

When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus

How did you get there? ❑ Ambulance or ❑ Private transportation

Name of Hospital and/or Attending doctor: _____

_____

Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: _____

_____

Were X-rays taken? ..... ❑ Yes ❑ No

Was medication prescribed? ..... ❑ Yes ❑ No

Have you been able to work since this injury? ❑ Yes ❑ No

Are your work activities restricted as a result of this injury? ❑ Yes ❑ No

Indicate ☑ the symptoms that are a result of this accident:

| | | | |
|---|---|---|---|
| ❑ Dizziness | ❑ Difficulty sleeping | ❑ Jaw problems | ❑ Nausea |
| ❑ Memory loss | ❑ Irritability | ❑ Arms/Shoulder pain | ❑ Back pain |
| ❑ Headache(s) | ❑ Fatigue | ❑ Numb Hands/Fingers | ❑ Lower back pain |
| ❑ Blurred vision | ❑ Tension | ❑ Chest pain | ❑ Back stiffness |
| ❑ Buzzing in ear | ❑ Neck pain | ❑ Shortness of breath | ❑ Leg pain |
| ❑ Ears ringing | ❑ Neck stiff | ❑ Stomach upset | ❑ Numb Feet/Toes |

❑ Other _____

Is your condition getting worse?

❑ Yes ❑ No ❑ Constant ❑ Comes & goes

**Indicate your degree of comfort while performing the following activities:**

| | Comfortable | Uncomfortable even if only sometimes | Painful |
|---|---|---|---|
| Lying on back | ❑ | ❑ | ❑ |
| Lying on side | ❑ | ❑ | ❑ |
| Lying on stomach | ❑ | ❑ | ❑ |
| Sitting | ❑ | ❑ | ❑ |
| Standing | ❑ | ❑ | ❑ |
| Stretching | ❑ | ❑ | ❑ |
| Lovemaking | ❑ | ❑ | ❑ |
| Walking | ❑ | ❑ | ❑ |
| Running | ❑ | ❑ | ❑ |
| Sports | ❑ | ❑ | ❑ |
| Working | ❑ | ❑ | ❑ |
| Lifting | ❑ | ❑ | ❑ |
| Bending | ❑ | ❑ | ❑ |
| Kneeling | ❑ | ❑ | ❑ |
| Pulling | ❑ | ❑ | ❑ |
| Reaching | ❑ | ❑ | ❑ |

Have you retained an attorney: ❑ Yes ❑ No

If yes, whom: _____

His/Her Phone #: _____

## four RECOVERY

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

How many hours are in your normal work day? _____

Please indicate ☑ your daily job duties and any activities which you are occasionally asked to perform.

| | | |
|---|---|---|
| ❑ Standing | ❑ Driving | ❑ Operating equipment |
| ❑ Sitting | ❑ Twisting | ❑ Work with arms above heac |
| ❑ Walking | ❑ Crawling | ❑ Typing |
| ❑ Lifting | ❑ Bending | ❑ Stooping |

❑ Other _____

What positions can you work in with minimum physical effort and for how long? _____ ❑ N/

Prior to the injury were you capable of working on an equal basis with others your age? .. ❑ Yes ❑ No ❑ N/

Do you work with others who can help you with any heavy lifting? ..... ❑ Yes ❑ No ❑ N/

While in recovery, is there any light duty work you could request? ..... ❑ Yes ❑ No ❑ N/

## five ADDITIONAL INSURANCE

**2nd Insurance Source or Auto Insurance**

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. ___/___/___

Insured's Employer: _____

Agent's Name: _____

**If any of your medical or account information has chang please inform our front desk personnel.**

**Please remember you are ultimately responsible for you account.**

_____ SIGNATURE ___/___/___ DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE

# General Pain Disability Index Questionnaire

Name (please print): _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

Use the letters below to indicate the type and location of your sensations right now

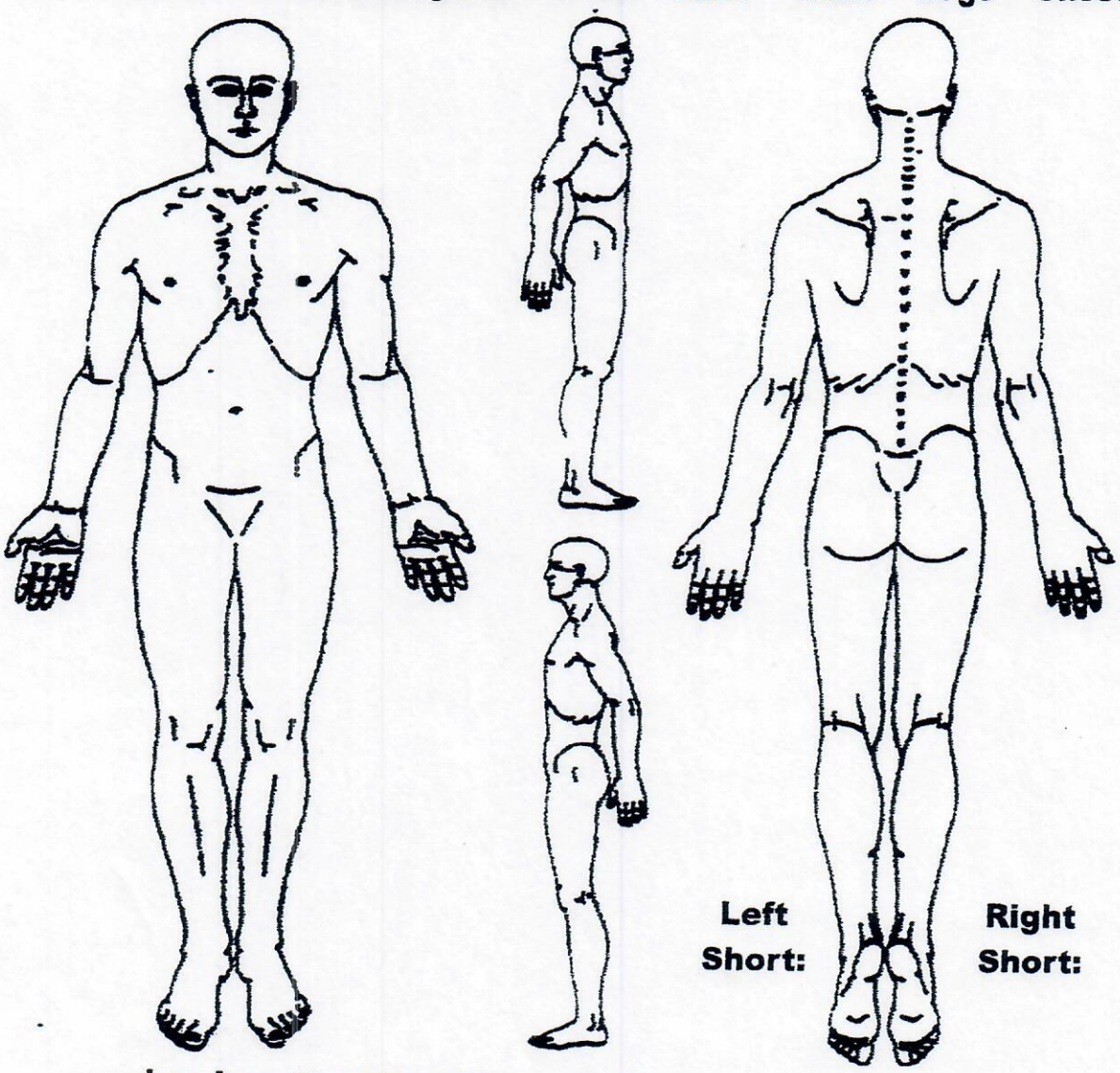
Key:

A = Ache
B = Burning
N = Numbness
P = Pins & Needles.
S = Stabbing
O = Others

**Circle → R → Radiating into: Head Face Arms Legs Chest**

**Height:**

**Weight:**



**Left Short:**

**Right Short:**

**Leg Lengths Affect Physical - Emotional Stability**

What activities do you do for exercise? _____

What activities are you unable to do? _____

DATE NAME: # REVIEW OF SYMPTOMS

**IMPORTANT:** Please check (X) all present

**HEAD:**
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

**NECK:**
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

**SHOULDERS:**
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Bursitis (R - L)
- ☐ Arthritis (R - L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R - L)
- ☐ Muscle spasms in shoulders

**ARMS & HANDS:**
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

**MID-BACK:**
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull Ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

**CHEST:**
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

**ABDOMEN:**
- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

**LOW BACK:**
- Low back pain
  - Upper lumbar
  - Lower lumbar
  - Sacroilliac
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down (sleeping)
  - walking
- Pain relieves when
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

**HIPS, LEGS & FEET:**
- Pain in buttocks (R - L)
- Pain in hip joint (R - L)
- Pain down leg (R - L)
- Pain down both legs
- Knee pain
  - Inside
  - Outside
- Leg cramps
- Cramps in feet (R - L)
- Pins & needles in legs (R - L)
- Numbness of leg (R - L)
- Numbness of feet (R - L)
- Numbness of toes
- Feet feel cold
- Swollen ankles (R - L)
- Swollen feet (R - L)

**WOMEN ONLY:**
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer _____
- ☐ Discharge
- ☐ Menopause _____
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

**MEN ONLY:**
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

**GENERAL:**
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep _____
- ☐ Loss of sleep _____ hrs /night
- ☐ Loss of weight _____ lbs.
- ☐ Gain weight _____ lbs
- ☐ Coffee _____ cups/day
- Tea _____ cups/day
- Cigarettes _____ pack/day
- Other _____
- Diabetes
- Hypoglycemia

**REMARKS:**

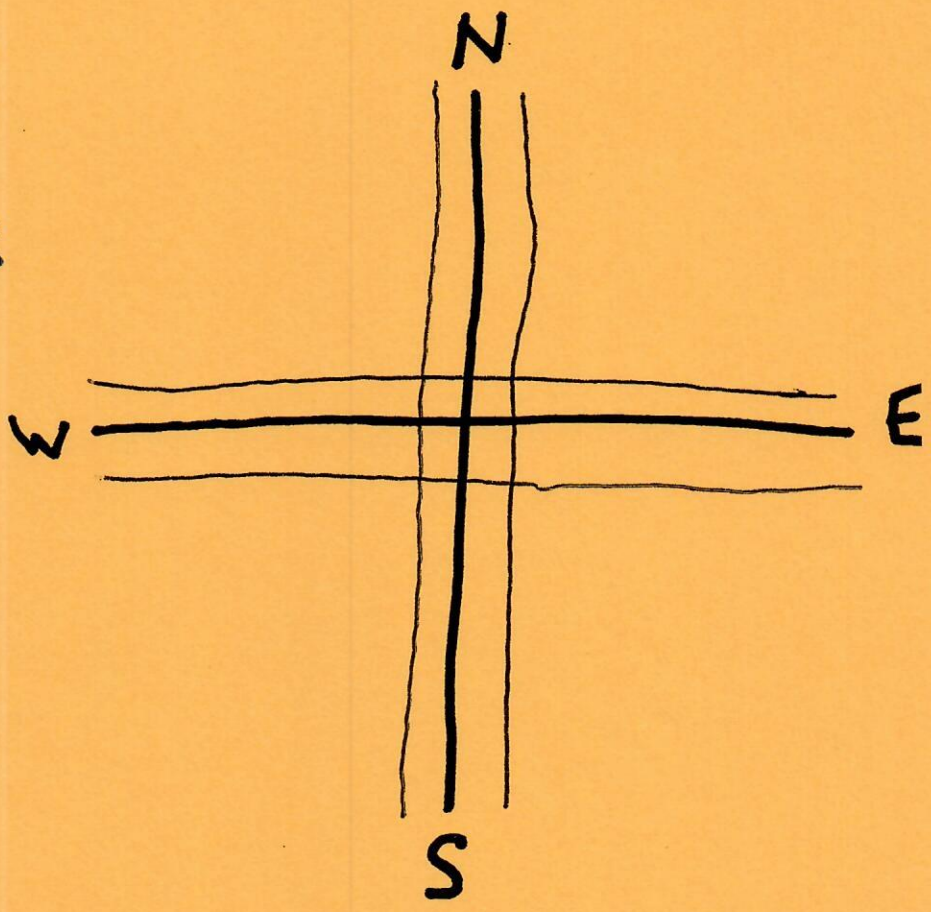
REV 11/94

# PLEASE DRAW A SIMPLE DIAGRAM OF YOUR ACCIDENT:

MY CAR = MC

OTHER CAR = OC

3RD CAR = 3C




OTHER NOTES:

DID POLICE COME TO THE ACCIDENT?

WAS A CITATION GIVEN? TO WHOM?

COMPLETE IF USING AN ATTORNEY:

# NOTICE OF DOCTOR'S LIEN

**Patient:** _____

**Date of Accident:** _____

I do hereby authorize DR. BOB SEILER to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

DATE _____ PRINT _____

Dated _____ _____

Patient's Signature

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

DATE _____ PRINT _____

Dated _____ _____

Attorney's Signature

Please date, sign and return one copy to doctor's office. Also keep one copy for your records.

Doctor: Dr R Seiler

Address: 150 S 600 E #6C

SLC, UTAH 84102