

Personal Injury / Accident Medical History Intake Form

Please allow our staff to photocopy your driver's license and accident information exchange card

PLEASE PRINT CLEARLY Full Name _____

Email _____ Gender M F Age: _____ Birth Date: _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Home Phone (____) _____ Cell phone (____) _____

Name of Spouse, Parent or Guardian _____ Age _____ Birth Date _____ SS# _____

Females: Are you or is there a possibility that you may be pregnant? ____ Y/N

Employer _____ Occupation _____ Wk Phone _____

In case of emergency contact _____ Relationship _____

Phone Number (____) _____ Cell (____) _____ Wk Phone (____) _____

Insurance/Attorney Information

Do you have MedPay? Y N

Insurance Company of the Person **at Fault** _____ **Name of Agent:** _____

Insurance Company Address: _____ City _____ St _____ Zip _____

Insurance Company Phone # _____ Agent's Phone # _____

Claim Number _____ Have you retained an attorney Y N

Your Attorney's Name _____ Phone # _____

Attorney's Address: _____

Accident Information

Date of Accident ____/____/____ **Time of Accident** _____ am pm **Location of accident** _____

Your Vehicle: Year _____ Make _____ Model _____ **Your Speed** _____

Other Vehicle: Year _____ Make _____ Model _____ **Their Speed** _____

Accident Type: Rear ended Head-on Broad-sided **Damage to Your Vehicle \$** _____ **Other Vehicle \$** _____

Describe Accident _____

What was your position in the vehicle? ____ Driver ____ Passenger

Who hit who? ____you were struck ____struck another vehicle

What was your vehicle's point of impact? _____ What was the *other* vehicle's point of impact? _____

What happened to your body at moment of impact? ____thrown back and forth _____thrown side to side

Where you wearing seat restraints? ____Y/N

What position were your vehicles head rest in? ____lowest position ____middle position ____highest position

Were you prepared for the impact?

____was completely surprised ____saw the collision coming ____saw the collision coming and braced accordingly

What position was your body in just prior to impact?

____straight ahead ____rotated left ____rotated right ____can't remember

What was your mental/emotional state immediately following the accident?

____was not rendered unconscious ____was not rendered unconscious but was shaken up and disoriented

____was rendered unconscious

Did you receive medical attention at the scene of the accident? ____Y/N

Where did you go immediately after the accident? ____hospital ____home ____resumed daily activities

Symptomatology (Pain Characteristics for Major Area of Complaint)

The pain started _____

The pain is made better by _____

and worse by _____

The pain has the following qualities _____

___ There is ___ There is not radiation into _____

___ There is ___ There is not referred pain into _____

___ There is ___ There is not parasthesia (tingling/numbness) into _____

The pain is located _____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.) _____

Daily Activities

How many days out of an average week do you have pain? _____

How much time out of an average day are you in pain? _____

What are the worst times of day for the pain? _____

What are the best times of the day for the pain? _____

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	___	___	___	___
Walking	___	___	___	___
Standing	___	___	___	___
Lying Down	___	___	___	___
Looking Up	___	___	___	___
Looking Down	___	___	___	___
Lifting	___	___	___	___

What do you do to relieve the pain? _____

What are some recreational activities that participated in before this current problem and which ones cannot be performed now to the same extent.

Please mark each that apply to your Daily Activities due to your problem:

- | | | |
|--|---|-----------------------------------|
| ___ Has difficulty climbing stairs | ___ Changes position frequently to try and get comfortable | ___ Has a loss of appetite |
| ___ Walks more slowly than normal | ___ Stays in bed most of the day | ___ Has difficulty sleeping |
| ___ Does not do jobs around the house | ___ Has to use handrails to get up stairs, etc. | ___ Can only walk short distances |
| ___ Has to lie down and rest frequently | ___ Has to hold onto something to sit or stand from a chair | ___ Has to sit most of the day |
| ___ Has to get other people to do things for you | ___ Has difficulty getting dressed due to problem | ___ Has difficulty bending |
| ___ Has become more irritable | ___ Has difficulty turning over in bed | |
| ___ Has to get dressed with someone's help | | |

How often do you have to stop activities and sit or lie down to control your symptoms?

___ Several times a day ___ Occasionally ___ Approximately once per day ___ Never ___ All Day

Social History: ___ Single ___ Married ___ Divorced ___ # of Children ___ Smoker ___ Non-Smoker ___ Drink Alcohol ___ Takes Drugs
 ___ Does not drink Alcohol ___ Does not take drugs

Pain Rating

On a scale of 1-10, rate your pain

No Pain _____ Severe Pain _____
 0 1 2 3 4 5 6 7 8 9 10

Describe the overall severity of the pain

- ___ Mild Nuisance
 ___ Mild to moderate but can live with it
 ___ Moderate, having trouble coping with it
 ___ Severe, it is ruining my quality of life

Progression: How is your pain compared to when the pain episode first started?

- ___ Much improved ___ Much worse
 ___ A little worse ___ No Change
 ___ Somewhat improved

Occupational History

Your Employer _____ **What is your current job satisfaction?**
 Job Title _____ Very Satisfied Satisfied Dissatisfied Very Dissatisfied

Are your Job Duties physically demanding for you? Y N **Have you had any disability time?** Y N

If you are currently working which are you performing? Regular Duties Limited – Light Duties

Medical History

List the Physicians and other practitioners you have seen for this problem: List the Medications you are currently taking:

List the treatments you have had for your problem

- Hot packs Ultrasound Chiropractic
- Massage Osteopathy Electrical Stimulation (EMS)
- TENS Unit Trigger Point Injections
- Epidural Injections
- Strengthening Exercises Back Brace Aerobics
- Acupuncture Traction Naturopathy Bed Rest

List the types of Diagnostic Testing for this problem

- X-rays CT Scan Myelogram MRI Scan
- Discogram Bone Scan EMG

List Past Surgeries: None

List Past Hospitalizations: None

List previous back, neck and musculoskeletal problems _____

Medical History

Mark if you have had any of the following symptoms in the past 5 years

- | | |
|--|--|
| <input type="checkbox"/> Unexplained fevers | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Weight loss of 10 lbs or more | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Persistent diarrhea |
| <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Excessive constipation |
| <input type="checkbox"/> Problems with depression | <input type="checkbox"/> Dark black stools |
| <input type="checkbox"/> Unusual stress at work | <input type="checkbox"/> Pain–burning when urinating |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Difficulty urinating – start/stop |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Need to urinate more at night |
| <input type="checkbox"/> Lumps in neck, armpit or groin | <input type="checkbox"/> Morning stiffness |
| <input type="checkbox"/> Chest pain or tightness | <input type="checkbox"/> Persistent eye redness |
| <input type="checkbox"/> Persistent or unusual cough | <input type="checkbox"/> Muscle tenderness |
| <input type="checkbox"/> Trouble breathing with exercise | <input type="checkbox"/> Dry eyes or mouth |
| <input type="checkbox"/> Trouble breathing lying flat | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Joint pain or swelling |

NOTES:

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. In addition to how your PHI will be used, office policies regarding payment and collections, and consent to treat are listed below. By signing at the end of these policies, you agree to all stipulations.

1. The patient understands and agrees to allow AZ Choice Chiropractic to use their PHI for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A Patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Arizona's Choice Chiropractic to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

AUTORIZATIONS, ASSIGNMENTS OF BENEFITS AND CONSENT TO TREAT

To: Arizona's Choice Chiropractic Doctors, hereafter referred to as OFFICE

1. I authorize, assign and direct my insurance carrier, to pay directly to said OFFICE such sums as may be due and owing the OFFICE of services rendered me, now or hereafter, which are payable under my insurance contract, or contractual agreement.
2. Patient agrees, that in the event patient receives any checks, drafts or other payment subject to this agreement, patient agrees to act as fiduciary agent to the OFFICE. The OFFICE agrees to apply any proceeds to the patient's debt for services rendered.
3. I fully understand and agree insurance policies are an arrangement between the insurance carrier and myself. I will be responsible for expenses not paid by insurance. I understand and agree that either health insurance or automobile insurance may not pay all of the charges of the OFFICE for my treatment. I understand and agree to pay the customary charges of the OFFICE and agree that if my health insurance or automobile insurance does not pay for my treatment in full, I will be responsible for the remaining balance. I understand and agree that I will be charged for missed appointments and that it may be necessary for OFFICE to record a lien on my case to ensure payment. I agree to pay the charges associated with filing of the lien.
4. I understand that if necessary of OFFICE to employ collection counsel and/or an attorney on my bill, I the patient will be responsible for any said collection and/or attorney fees.
5. I understand that if I do not cancel a scheduled massage appointment 24 hours in advance of the appointment I may be charged a \$25.00 cancellation fee.
6. I agree the OFFICE has the right to call my home or place of employment regarding appointment or insurance issues.
7. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, nutritional assessment, and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or licensed doctors of chiropractic who now or in the future treat me while employed by, or are associated with or serving as back-up for the doctor of chiropractic, including those working at the clinic or office or any other office or clinic.
8. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interests.
9. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) I seek treatment.
10. A photocopy of this form shall be as valid as original

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

 Patient's signature

 Date

 Legal guardian if patient is a minor

 Relationship to minor