REEDCHIROPRACTIC

New Patient Registration and Accident Questionnaire ❶

Name: ______________________________________ Age: _________ Date of birth: ____________ Date: __________
LAST FIRST MIDDLE

Address: ____________________________________ Social Security #: ______________________ ☐ Male ☐ Female

City, State, Zip: ______________________________ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children__________

Home Phone (_____)____________________________ Work Phone (_______) ________________________________

Cell Phone (_____) _____________________________ Email address: _______________________________________

Employer: ____________________________________ Spouse's Name: ______________________________________

Occupation: __________________________________ Spouse's Employer: ____________________________________

In case of emergency, notify______________________ Relationship: ____________ Phone (_______) ___________

Current Symptoms: 1.__________________ 2.__________________ 3.__________________ 4.__________________

5. __________________ 6. __________________ 7. __________________ 8. __________________

When did your symptoms begin? ____

In general what makes your symptoms better? ____

In general what makes your symptoms worse? ____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): _______________________________

Are your symptoms local or do they travel to another area? (If they travel, to where?) ______________________________

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

____

Please list all medications and dosage:	**Frequency**	**For What Illness?**

List any allergies to medications, foods or other: ____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle:
____

Do you smoke? ☐ Yes ☐ No; How much? ___________ Do you drink alcohol? ☐ Yes ☐ No; How much? ___________

Please list all serious illness and serious accidents:	**Month and Year**	**City, State**

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Mesa:6025 E. Mckellips Rd. #102 Mesa, AZ 85215
Phone: 480.785.1355 Fax: 480.222.0453

Patient's Name: ______________________________ Date: ______________

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

____

____

Date of Crash/Accident: ____________________ Hour: ________ ☐ AM ☐ PM

Specific Location of Crash/Accident: ______________________________

Describe in detail, in your own words, how the crash/accident happened: ____________________

____

____

____

AUTOMOBILE/MOTORCYLCE ONLY

In the crash/accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? ______________

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐Left Side ☐ Right Side

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on ______________ (Street/Highway)

Was the other heading? ☐ North ☐ South ☐ East ☐ West on ______________ (Street/Highway)

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ *Headache*
☐ Neck Pain
☐ Neck Stiffness
☐ *Sleep Disruption*
☐ *Depression*
☐ *Anxiety*
☐ *Fainting*
☐ *Muscle Spasms*
☐ Middle Back Pain
☐ Chest Pain
☐ *Bruised Chest*
☐ *Bruising Anywhere*
☐ *Blurred Vision*
☐ Sensitivity to Light
☐ Upper Arm Pain
☐ Lower Arm Pain
☐ Lower Back Pain
☐ Lower Back Stiffness
☐ *Radiating Pain*
☐ Tingling in Legs
☐ Tingling in Arms
☐ *Jaw Pain (TMJ)*
☐ Upper Leg Pain
☐ Lower Leg Pain
☐ *Ears Ring*
☐ *Buzzing in Ears*
☐ *Dizziness*
☐ Loss of Smell
☐ Loss of Taste
☐ *Any Burns*
☐ *Any Stitches*
☐ *Any Cuts*

☐ Other Symptoms: ______________________________

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: ____________ to ____________

Where did you go after the crash/accident? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other __________

Were you taken by ambulance? ☐ Yes ☐ No **To which hospital?** ______________________

Address: ______________________________ Date of Hospitalization: ______________

Attending E.R. Doctor: ____________________ Treatment Given? ____________________

Have you done any of the following since the crash/accident?:

☐ Ice ☐ Medication (name) __________ ☐ Rest
☐ Heat (any kind) ☐ Exercise ☐ Other__________

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Patient's Name: ______________________________ Date: ____________

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: ______________________________

Address: ____________________Telephone: (_____) __________Insured: __________

Claim #: ____________________Policy #: ____________________

Claim Representative: ______________

Telephone: (______) ______________ Fax: (_______) ______________

Med-Pay Benefits: _______ Uninsured (UM) Benefits: _______ Underinsured (UIM) Benefits: _______

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

2) YOUR HEALTH INSURANCE COMPANY: ______________________________

Address: ____________________ Insured: ____________________

Date of Birth: ______________Policy #: ______________ SS#: __________

Telephone: (______) ______________ Fax: (_______) ______________

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: ____________________

Address: ____________________ Claims Rep: ____________________

Claim #: ____________________Policy #: ______________Insured: __________

Telephone: (______) ______________ Fax: (_______) ______________

4) ATTORNEY: ____________________Legal Assistant: ______________

Address: ____

Telephone: (______) ______________ Fax: (_______) ______________

HIPAA Compliance

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: ____________________ Date:____________________

Witness: ______________________________Date: ____________________

Staff Initials: __________