REEDCHIROPRACTIC

New Auto Accident Questionnaire

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. _____

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

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

☐ Other Symptoms: _____

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

_____

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? _____

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

REEDCHIROPRACTIC

Patient's Name: _____ Date: _____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

Symptom # __ _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - **Did you have this symptom before this motor vehicle collision?** Yes / No
        - If so, what was the intensity (scale of 1-10) and frequency? _____
        - Since the accident has the symptom: gotten better / stayed the same / worsened
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
      Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

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REEDCHIROPRACTIC

Patient's Name: _____ Date: _____

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

_____

_____

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

_____

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

_____

_____

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)

Was your car towed from the scene? ☐ Yes ☐ No: If no, did you drive your car away from the scene? ☐ Yes ☐ No

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_____

REEDCHIROPRACTIC

Patient's Name: _____ Date: _____

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: _____

NOTICE OF DOCTOR'S LIEN

I do hereby authorize **Reed Chiropractic/David T. Reed, D.C** to furnish my attorney/3rd party insurance company named above with a full report of my examination, diagnosis, treatment, prognosis, ect with regards to the incident in which I was recently injured.

I further authorize and direct my attorney/3rd Party Insurance Company to pay directly to **Reed Chiropractic/David T. Reed, D.C** such sums as may be due and owing for medical services rendered to me both by reason of this incident and by reason of any other bills that are due and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctors.

I hereby further give a Lien on my case to **Reed Chiropractic/David T. Reed, D.C** against any and all proceeds of my settlement, judgment, or verdict which be recovered or paid as the result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any recovery made by me. I hereby agree to waive the defense of Statute of Limitations as it pertains to any claim filed against me beyond three years (or other statutory) after services were rendered. 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 of added attorney(s).
I have been advised that if I choose not to sign this document, the doctor will not await payment, and charges will be payable at the time of service.

_____ _____

Date Patient's Signature

_____

Patient's Printed Name

250 W. Baseline Rd. #107 Tempe, AZ 85283
Phone: 480.785.1355 Fax: 480.222.0453

Health Care Authorization

Print Name: _____ Today's Date: _____

The patient identified above authorizes Reed Chiropractic to use and/or disclose protected healthcare information in accordance with the following: I give permission to Reed Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, birthday messages and holiday cards as well as information about treatment alternatives or other related health information.
By signing this form, you are giving Reed Chiropractic to use and disclose your protected health information in accordance with the directives listed above. I am aware of Dr. David T Reed's Notice of Privacy Practices. A Full copy is available at my request.

Signature: _____

Terms of Acceptance

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic DOES NOT diagnose or treat disease. Chiropractic only has one goal:

TO LOCATE, ANALYZE, AND CORRECT SPINAL INTERFERENCE
IN THE NERVOUSE SYSTEM

The purpose of the nervous system is to control and coordinate all bodily functions. Interference to this master control system causes improper functioning of the body. The SUBLAXATION (spinal misalignment producing nerve interference) in and of itself, is a detriment to life and your health. Correction of a sublaxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

- WE DO NOT DIAGNOSE CONDITIONS OR DISEASES OTHER THAN VERTABRAL SUBLAXATIONS
- WE DO NOT OFFER TREATMENT FOR CONDITIONS OR DISEASES OTHER THAN VERTABRAL SUBLAXATIONS
- WE DO NOT PROMISE A CURE FROM ANY CONDITIONS OR DISEASES
- THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO THEIR FULLEST POTENTIAL

I, _____, having read the above statement and understanding fully, do undertake chiropractic health care on this basis.

Signature: _____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential side effects on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to a cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissections" that typically is caused by a tear in the inner layer of the artery that mc cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, mediations, and vessel abnormalities have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in a one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events per one million person/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other options about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate this it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____Signature:_____Date:_____

Parent or Guardian: _____Signature:_____Date:_____

Witness name: _____Signature:_____Date:_____

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