Name _____Address: _____

City _____ State _____ Zip _____ Home # _____

Cell # _____Email _____

SSN _____Date of Birth _____ Age _____ Weight _____ Height _____

Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ # of children _____Name of spouse (or parent) _____

Employer _____ Address _____

City _____State _____Zip _____Work # _____ Occupation _____

What is the name of your family physician? _____City Located? _____

Have you ever had Chiropractic care? ❑ Yes ❑ No If yes, doctor name: _____ Date of last visit _____

If you are experiencing any pain (neck, low back, etc.), health problems, symptoms, and/or complaints, please list in order of severity

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting ❑ worse or ❑ Staying the same?
Currently or in the past have you ever experienced any of these complaints while working? ❑ Yes ❑ No If yes, please describe the activities at work may be causing these complaints: _____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? ❑ Yes ❑ No
If yes, please explain _____

Have you at any time in the past ever suffered a work injury? ❑ Yes ❑ No If yes, what is the date of injury? _____

Do you have an attorney representing you for this work injury ? ❑ Yes ❑ No If yes, who is your attorney? _____

Have you been involved in an auto accident in the last 12 months? ❑ Yes ❑ No If yes, date of auto accident? _____

Do you have an attorney representing you for this auto accident? ❑ Yes ❑ No If yes, who is your attorney? _____

How many other passengers were in the car with you? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

If due to an auto accident, what is the name of your auto insurance company? _____

Have you ever had any surgeries or hospitalizations? ❑ Yes ❑ No If yes, please list _____

Please list any current or past injuries and illnesses not listed above _____

Please check all medications (over the counter and/or prescribed) you are currently taking ❑ Asprin/tylenol ❑ Pain killers ❑ Insulin ❑ Muscle Relaxers ❑ Birth Control ❑ Sleeping pills ❑ Anti-depressants ❑ Other _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

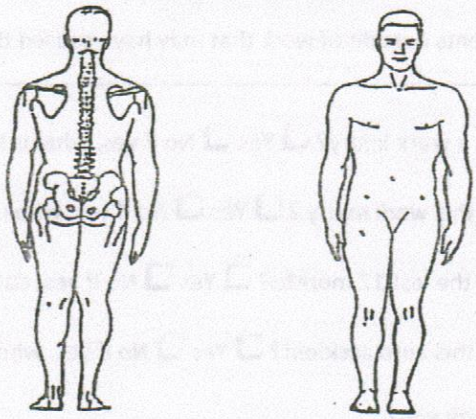
0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____
2. RECREATION: hobbies, sports, and other similar leisure time activities. _____
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature _____ Date _____

Patient's Accident Account

Date of Accident _____ Time _____AM / PM
Location of Accident or Injury _____
Type of Accident (Select One) □ Auto Collision □ Work Accident □ Other _____
Year/Model of Your Car _____ Year/Model of Other Car _____
Please Describe the Accident or Injury (in as much detail as possible):

_____

_____

_____

Auto Injury Questions:

Were you the (Select One):	□ Driver	□ Passenger	□ Pedestrian		
Were you struck from (Select One):	□ Behind	□ Front	□ Left Side	□ Right Side	□ Parked
Did your car strike others involved:		□ Yes	□ No		
Did the other car strike yours:		□ Yes	□ No		
Did you have a seat belt on:		□ Yes	□ No		
Did any part of your body strike the car:		□ Yes	□ No Which? _____		
Were traffic citations issued to you:		□ Yes	□ No		
Issued to other drivers:		□ Yes	□ No		
To the driver of the car you were in:		□ Yes	□ No		

Work Injury Questions:

Was your employer notified:	□ Yes	□ No
Did the employer refer you anywhere:	□ Yes	□ No

Please Describe How You Felt After the Accident (in as much detail as possible):

_____

_____

Chief Current Complaint(s): place an (x) in the appropriate complaint areas.

Spine	Upper Extremity	Lower Extremity
□ Low Back	□ Shoulder R L	□ Hip R L
□ Mid Back	□ Arm R L	□ Thigh R L
□ Neck	□ Elbow R L	□ Knee R L
□ Pelvis	□ Wrist R L	□ Leg R L
	□ Forearm R L	□ Ankle R L
	□ Hand R L	□ Foot R L

Please Read Carefully & Check Any Symptoms That You Have Noticed Since the Accident or Injury?

□ Headache	□ Dizziness	□ Loss of Memory	□ Ringing in Ears
□ Neck Pain	□ Head Seems Heavy	□ Face Flushed	□ Loss of Balance
□ Neck Stiff	□ Pins & Needles in Arms	□ Pins & Needles in Legs	□ Fainting
□ Sleeping Problems	□ Numbness in Fingers	□ Numbness in Toes	□ Loss of Smell
□ Back Pain	□ Shortness of Breath	□ Upset Stomach	□ Loss of Taste
□ Nervousness	□ Light Bother Eyes	□ Tension	□ Constipation
□ Irritability	□ Buzzing in Ears	□ Depression	□ Diarrhea
□ Chest Pain	□ Cold Hands	□ Lightheadedness	□ Cold Sweats
□ Fatigue	□ Cold Feet	□ Fever	□ _____
□ _____	□ _____	□ _____	□ _____

Did you feel any popping, tearing or ripping in your neck or back? □ Yes □ No
Did you have any bruises? □ Yes □ No Where? _____
Have you been treated before for any of these symptoms? □ Yes □ No
Did you go to the Emergency Room? □ Yes □ No Where? _____
Were you Examined? □ Yes □ No
Were you X-Rayed? □ Yes □ No
Was there treatment given? □ Yes □ No
Medication? □ Yes □ No

Have you seen any other doctors? □ Yes □ No Who? _____
_____
Have you lost any days from work? □ Yes □ No How Many? _____

ACTIVITIES OF DAILY LIVING: SYSTEM REVIEW
Place an (x) next to the symptoms you know you have

Current Pain Level (scale of 0-10)
No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Pain Intensity
□ I can tolerate the pain I have without painkillers
□ The pain is bad but I manage w/o taking painkillers
□ Painkillers give complete relief from pain
□ Painkillers give moderate relief from pain
□ Painkillers give very little relief from pain
□ Painkillers give no relief from pain; I do not use them

Personal Care (washing, dressing, driving, etc)
□ I can look after myself normally w/o extra pain
□ I can look after myself normally but causes extra pain
□ It is painful to look after myself; I am slow and careful
□ I need some help but manage most of my personal care
□ I need help every day in most aspects of selfcare
□ I do not get dressed, wash with difficulty & stay in bed

Lifting
□ I can lift heavy weights without extra pain
□ I can lift heavy weights but it causes extra pain
□ I can only lift heavy weights from convenient location
□ I can only lift light to medium weights
□ I can lift only very light weights
□ I cannot lift or carry anything at all.

Walking
□ Pain does not prevent me from walking any distance
□ Pain prevents me from walking more than one mile
□ Pain prevents me from walking more than ½ mile
□ Pain prevents me from walking more than ¼ mile
□ I can only walk using a cane or crutches
□ I am in bed most of the time; have to crawl to the toilet

Sitting
□ I can sit in any chair as long as I like
□ I can only sit in my favorite chair as long as I like
□ Pain prevents me from sitting for more than one hour
□ Pain prevents me from sitting for more 30 minutes
□ Pain prevents me from sitting for more 10 minutes
□ Pain prevents me from sitting at all

Standing
□ I can stand as long as I want without pain
□ I can stand as long as I want but it causes extra pain
□ Pain prevents me from standing for more than 1 hour
□ Pain prevents me from standing for more 30 minutes
□ Pain prevents me from standing for more 10 minutes
□ Pain prevents me from standing at all

Sleeping
□ Pain does not prevent me from sleeping well
□ I can sleep well only by using tablets
□ Even when I take tablets I have less than 6 hours sleep
□ Even when I take tablets I have less than 4 hours sleep
□ Even when I take tablets I have less than 2 hours sleep
□ Pain prevents me from sleeping at all

Sex Life
□ My sex life is normal and causes no extra pain
□ My sex life is normal but it causes some extra pain
□ My sex life is nearly normal but is very painful
□ My sex life is severely restricted by my pain
□ My sex life is nearly absent because of pain
□ Pain prevents any sex life at all

Social Life
□ My social life is normal and gives me no extra pain
□ My social life is normal but increases pain
□ Pain limits my energetic interests (exercise, etc.) only
□ Pain has restricted my social life; I don't go out often
□ Pain has restricted my social life to my home
□ I have no social life because of pain

Travel
□ I can travel anywhere without extra pain
□ I can travel anywhere but it gives me extra pain
□ Pain is bad but I manage journeys over two hours
□ Pain restricts me to journeys of less than one hour
□ Pain restricts me to short necessary trips under 30 min
□ Pain restricts me from traveling except to the doctor

Patient Signature: _____ Date: _____

Printed Name:_____

Personal Injury Insurance Information

Today's Date:_____ Accident Date:_____

Name:_____ Driver Passenger

Please provide as much information as possible so your case can be set up to your financial advantage.

Fault-based Insurance Coverage (liability, uninsured motorist coverage):

Insured's Name:_____ Phone #:_____._____

Insurance Name:_____ Phone #:_____

Policy #:_____ Claim #:_____

Adjuster's Name:_____ Phone #:_____

Claims Mailing Address: _____

No-fault coverage:

Medpay is an optional benefit that you may have purchased to cover any medical expenses. It covers you regardless of what vehicle you were occupying at the time of the accident and it also covers any person occupying your vehicle at the time of the accident. **Using this portion of the policy cannot raise your premium or affect your records in any way.**

Do you have Medpay coverage? Yes No If yes, what is the coverage limit? $_____

Insurance Name:_____ Phone #:_____

Policy #:_____ Claim #:_____

Claims Mailing Address: _____

Health Insurance coverage (HMO,PPO):
Do you have alternate insurance coverage (i.e through your employer) that you would like us to bill? Yes No
If yes, please read:

In the state of Arizona, insurance laws read that you have the right to bill any insurance policy under which you have coverage. Some employee benefit plans have subrogation clauses. Please read the attached information sheet on subrogation and contact your insurance carrier to see how they will handle payment for your medical bills.

Insured's Name:_____ Relationship: self spouse child

Insurance Name:_____ Phone #:_____

ID #:_____ Group #:_____

Attorney Representation:

The primary function of an attorney is to pursue liability and UM/UI coverages for any type of damages recognized by law, most notably, pain and suffering. Do you have an attorney? Yes No

Name:_____ Phone #:_____

Subrogation: what it is and how it works

Suppose you're in a car accident and it is clearly not your fault. Your car is wrecked and your neck and back have been injured. You are covered for both the damage to your car and your personal injuries, and so you call your insurance company and they pay all of your expenses relating to the accident. Later, your insurance company, realizing that the other party at fault also has insurance that will cover the damages, seeks out reimbursement from that insurance company since its insured was actually at fault for the accident. This is called *subrogation.*

Subrogation refers to an insurance company seeking reimbursement from the person or entity legally responsible for an accident after the insurer has paid out money on behalf of its insured. The general rule is that, after paying your claim, your insurer is "subrogated" to the rights of your policy and can "step into your shoes" to go after or sue the negligent party on your behalf. Not all insurers subrogate for medical bills. If they do, it could be against the other driver's insurance, but it could also be against your own separate health insurance policy or any other medical insurance that would cover your treatment.

Subrogation may also be employed when your insurer settles your collision claim for damage to your vehicle due to another driver's negligence. Generally, your insurer will have you sign a subrogation release that assigns your right of recovery against the person responsible for your loss to them. Insurers may not stall settling your claim until they get paid from the person at fault. Subrogation usually occurs some time after the original claim is settled. Some insurers will include the deductible when they subrogate and you will get your deductible back when the other driver or their insurance company pays the subrogation claim.

What if the accident was your fault?

If the accident was your fault, you are responsible for the damages caused. If the accident was only *partly* your fault, you may be only responsible for a portion of the damages depending on the laws of your state. The other driver's insurance company will likely subrogate against you or your insurance company to pay for the damage to their insured's car and/or their medical bills. Keep in mind that often you can negotiate the amount of damages that is being claimed and pay out the amount over time. If you don't have insurance and a claim is being subrogated against you, it is a good idea to contact a car accident lawyer to make sure you are not getting taken.

Be patient, but keep on top of your claim.

It is best to cooperate with your insurer, within reason of course, when a subrogation claim has been made. In most cases, the two insurance companies are going back and forth to verify what happened and what amounts have been paid out. Unfortunately, this takes time – sometimes too much time. Be patient, but keep in close contact with your claims person so your claim doesn't get pushed to the bottom of the pile!