

**Chandler Chiropractic | 2100 W Chandler Blvd, Chandler 85224 | 480.899.9855**

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 \_\_\_\_\_



## 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

- Low Back
- Mid Back
- Neck
- Pelvis

#### Upper Extremity

- Shoulder R L
- Arm R L
- Elbow R L
- Wrist R L
- Forearm R L
- Hand R L

#### Lower Extremity

- Hip R L
- Thigh R L
- Knee R L
- Leg R L
- Ankle R L
- Foot R L

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

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

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

**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

**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

**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

**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.

**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

**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

**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!