MADEIRA CHIROPRACTIC AND REHABILITATION

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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? ___________

Current Height __________ Current Weight __________

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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**

____

____

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/MOTORCYCLE 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

Your vehicle: ☐ Car ☐ Pick-up Truck ☐ Van ☐ SUV / Other vehicle: ☐ Car ☐ Pick-up Truck ☐ Van ☐ SUV

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*	☐ 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: ____________________________________

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? ____________________

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

☐ Ice ☐ Medication (name) ________________ ☐ Rest

☐ Heat (any kind) ☐ Exercise ☐ Other________________

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: ________________

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