Moon Valley Chiropractic Jamey Reichow, DC

15420 N. 7th Street, Ste B Phoenix AZ, 85022 (602) 298-0292 Fax (602) 298-6961

Date of Accident: _____ Hour: _____AM _____PM _____

Specific Location of Accident: _____

Describe in detail, in your own words, how the accident happened: _____

_____

_____

In the accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____

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

Were you struck from: ☐ Behind ☐ Front ☐ Side Impact ☐ Driver's Side ☐ Passenger's Side

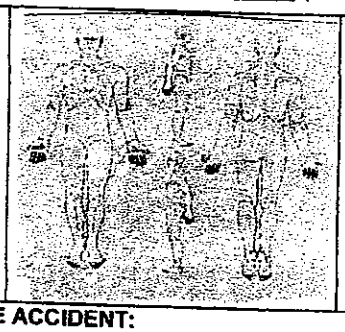
Were traffic citations issued to: ☐ You ☐ the Driver of Your Car ☐ the Driver of the Other Car ☐ No Citations Given

Was your car heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Was the other heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Please mark on the diagram to the right the following symbols as they relate to your symptoms:

SS = spasms ST = stiffness
DP = dull pain SP = sharp pain
SH = shooting pain TI = tingling
NU = numbness O = Other



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

☐ Headache
☐ Neck Pain
☐ Neck Stiffness
☐ Sleeping Problems
☐ 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
☐ Upper Leg Pain
☐ Lower Leg Pain
☐ Ears Ring
☐ Buzzing in Ears
☐ Dizziness
☐ Loss of Smell
☐ Loss of Taste
☐ Any Bums
☐ Any Stitches
☐ Any Cuts

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

Employer: _____ Employers Telephone: _____

Did you go to the hospital? ☐ Yes ☐ No: If Yes, Name of Hospital or E.R: _____

Address: _____ Date of Hospitalization: _____

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

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

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Patient _____ Date_____ **Dr Signature**_____

Were police on-scene? ☐ Yes ☐ No If yes, was a report made? ☐ Yes ☐ No
After the crash symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐Confusion/disorientation
☐ Neck pain ☐ Paresthesia ☐ Back pain ☐ Other _____
When did symptoms first appear? ☐ Immediately ☐ Same day ☐ Next day ☐ Other _____

Where did you go after accident? ☐ Home ☐ Work ☐ Hospital Mode of transportation _____
Emergency room: ☐ Yes ☐ No Hospital name: _____ X-rays: ☐ Yes ☐ No
Body parts x-rayed _____ Results _____

Lab work ☐ Yes ☐ No Results: _____ Cervical collar ☐Yes ☐No
☐ Ice ☐ Rx_____ Other _____
Follow-up Instructions: _____ ☐ None

Treatment history:
Doctor: _____ Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____ Treatment frequency: _____
Treatment duration: _____ Currently treating? ☐ Yes ☐ No
Additional tests: _____
Did treatment help? ☐ Yes ☐ No Notes: _____

Treatment history:
Doctor: _____ Specialty: _____ Date first seen: _____
Referred by: _____ Treatment type: _____ Treatment frequency: _____
Treatment duration: _____ Currently treating? ☐ Yes ☐ No
Additional tests: _____
Did treatment help? ☐ Yes ☐ No Notes: _____

Current Chief Complaints

1._____Onset_____Provocative_____
Palliative_____ Quality_____
Radiation/Location_____
Severity (VAS): *Now*: _____; *Ave.*: _____; *Min. To Max Range.*: ____ - ____ /10
Time: Better Am Worse Better Pm Worse
Frequency: <25% Intermittent 26-50% Occasional 51-75% Frequent > 76% Constant

2._____Onset_____Provocative_____
Palliative_____ Quality_____
Radiation/Location_____
Severity (VAS): *Now*: _____; *Ave.*: _____; *Min. To Max Range.*: ____ - ____ /10
Time: Better Am Worse Better Pm Worse
Frequency: <25% Intermittent 26-50% Occasional 51-75% Frequent > 76% Constant

3._____Onset_____Provocative_____
Palliative_____ Quality_____
Radiation/Location_____
Severity (VAS): *Now*: _____; *Ave.*: _____; *Min. To Max Range.*: ____ - ____ /10
Time: Better Am Worse Better Pm Worse
Frequency: <25% Intermittent 26-50% Occasional 51-75% Frequent > 76% Constant

4._____Onset_____Provocative_____
Palliative_____ Quality_____
Radiation/Location_____
Severity (VAS): *Now*: _____; *Ave.*: _____; *Min. To Max Range.*: ____ - ____ /10
Time: Better Am Worse Better Pm Worse
Frequency: <25% Intermittent 26-50% Occasional 51-75% Frequent > 76% Constant

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Patient _____ Date_____ Dr Signature_____

PAST HISTORY

Previous Injuries (MVA, WC, Sports)

_____

_____

Previous Treatment History / History of Current Complaints / Prior Treatment by DC

Date	Dr/Hosp	Treatment	Response (+) (-) (NC)	Treatment Duration	Test(s)	Test Result

Past Hospitalizations / Illness / Fractures ☐ None_____
Surgical History (Date and Residuals) ☐ None _____
General State Of Health_____ Allergies_____
Medications/Vitamins_____

Family History 1. Father, 2. Mother, 3. Sister (A, B, C, D), 4. Brother (A, B, C, D)
Cancer ( )_____Diabetes ( )_____; Cardiac ( )_____
CVA ( )_____; BP ( )_____; Epilepsy ( )_____;
TB ( )_____
Other_____

Psycho-Social History

Date	Occupation	WC Claims	Disabilities	Enjoyed

Activities Of Daily Living (Changes As A Result Of Injury):

_____

Recreational/Exercise: Type: _____
Freq. ____/Wk; Duration _____ Min. / Hrs;_____

Social History
Marital Status: ☐ Single, ☐ Married, ☐ Divorced, ☐ Widowed
Educational Level: ☐ < High School; ☐ H.S. Grad.; ☐ College (Yrs:___) Degree: _____; Tech. (Yrs___) Dipl.: ____

Social Habits (Circle Appropriate Responses And Fill In The Blank)
Tobacco: ___ Pk / ___Day, Wk, For ___ Yrs; **Chew** ___ Yrs; **Pipe**___ Yrs **Caffeine (Soda, Coffee, Tea)** _____/ Day
Alcohol ____ Glasses Of Wine, Beer, Mixed Dr. / Day, Wk, Mo. **Sleep Interrupted?** ____ X's / Night For ____ Wks Mo Yrs

Work Routine	*Able*		*Restricted*		*Unable*	
Sit in office chair	1	2	3	4	5	
Stand erect	1	2	3	4	5	
Climb steps / stairs	1	2	3	4	5	
Stoop to retrieve	1	2	3	4	5	
Crouch to retrieve	1	2	3	4	5	
Kneel to retrieve	1	2	3	4	5	
Reach overhead	1	2	3	4	5	
Lift; waist to shoulder height	1	2	3	4	5	
Carry object, 100 feet	1	2	3	4	5	
Push	1	2	3	4	5	
Pull	1	2	3	4	5	
Balance	1	2	3	4	5	
Crawl	1	2	3	4	5	
Reach	1	2	3	4	5	
Handle objects appropriately	1	2	3	4	5	
Finger/Hand strength/coordination	1	2	3	4	5	

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Patient _____ Date _____

REVIEW OF SYSTEMS

0 = NEVER HAD 1 = PATIENT PRESENTLY HAS 2 = PREVIOUSLY HAD 3 = RELATED TO CRASH (Date: _____)

GENERAL
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight loss
___Nervousness/depression
___Neuralgia
___Numbness
___Sweats
___Tremors

EYES, EARS, NOSE, THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
___Gum trouble
___Hay fever
___Hoarseness
___Nasal obstruction
___Near sighted

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Foot Trouble
___Hernia
___Low back pain
___Lumbago
___Neck pain/stiffness
___Shoulder blade pain
Pain or numbness in:
___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Feet
___Painful tailbone
___Poor posture
___Sciatica
___Spinal curvature

GENITO-URINARY
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Pus in urine
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts

CARDIOVASCULAR
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY
___Chest pain
___Chronic cough
___Difficult breathing
___Spitting up blood
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Belching or gas
___Colitis
___Colon trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Gall bladder trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting
___Vomiting blood

Other: _____

Physician/Staff Signature _____

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PLEASE CHECK (✓) AS MANY OF THE FOLLOWING STATEMENTS THAT APPLY TO YOUR CASE.

☐ I have medical payment (Med-Pay) benefits, either, personally or through the driver of my vehicle.
☐ I have group health insurance benefits either directly or through my spouse or parents.
☐ I have retained an attorney.
☐ I have not retained an attorney.
☐ I have the adverse or third party information available. (Insurance company of the other driver.)

PLEASE PROVIDE THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone:(____) _____ Insured: _____

Claim #: _____ Policy #: _____

Telephone: (____) _____ Fax: (____) _____

2) YOUR GROUP HEALTH INSURANCE COMPANY: _____

Address: _____ Telephone: (____) _____ Insured: _____

Date of Birth: _____ Policy #: _____ SS#: _____

Telephone: (____) _____ Fax: (____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Telephone: (____) _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

Telephone: (____) _____ Fax: (____) _____

4) Attorney: _____ Legal Assistant: _____

Address: _____

Telephone: (____) _____ Fax: (____) _____

HIPAA Compliance

Moon Valley Chiropractic 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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Patient Registration and Personal Injury History 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 (_____) _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify _____ **Relationship:** _____ **Phone** (_____) _____

Chief Complaint or Reason for Office Visit: _____

Specific Date and Time of Onset of Symptoms: _____

What makes your symptoms better? _____ What makes your symptoms worse? _____

What is the quality of your symptoms? (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**

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**

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

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MOTOR VEHICLE CRASH HISTORY

Time In: _____
Time Out: _____
Doctor _____

Date Of Accident _____
Date Of Exam _____
Doctor Signature _____

Patient _____ Age _____
Birth Date _____ Sex: M F Marital Status _____
Spouse Name _____ # of Children _____
Occupation _____ Years _____ Employer _____
Unemployed due to accident?: ☐Yes ☐ No Type of Work: ☐Office /Clerical ☐Light ☐Moderate ☐Heavy Labor

Was the accident on-the-job? ☐ Yes ☐ No
Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Rear Seat Passenger
☐ Motorcycle Operator ☐ Motorcycle Passenger ☐ Other _____
Vehicle driven by _____

Did your car strike another? ☐ Yes ☐ No Did the other car strike your car? ☐ Yes ☐ No
Were you struck from: ☐ Behind ☐ Front ☐ Driver's side ☐ Passenger's side ☐ other _____
Were traffic citations issued to: ☐ You ☐ Driver of your car ☐ Driver of other car ☐ None

Was your car heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/highway)
Was the other car heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/highway)
Your Vehicle (Year, Make, Model) _____
Your estimated speed at the moment of accident: ☐ Full Stop ☐Slowing ☐Accelerating
Other Vehicle (Year, Make, Model) _____

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark
Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____
Head restraints: ☐ None ☐ Integral type ☐ Adjustable: ☐ Up ☐ Down ☐ Don't know
If adjustable, was the position altered by the accident? ☐ Yes ☐ No
Was the seat back adjustment altered by the accident? ☐ Yes ☐ No
Did air bag deploy? ☐ Yes ☐ No If Yes, were you struck? ☐ Yes ☐ No Were you burned? ☐ Yes ☐ No

Body position: ☐ Good ☐ Forward lean ☐ Other _____
Head position: ☐ Forward ☐ Left _____° ☐ Right _____° ☐ Up _____° ☐ Down _____°
Hands: ☐ One on wheel ☐ Two on wheel ☐ N/A **Brakes applied at impact?** ☐ Yes ☐ No

Accident Description (See Enclosed WC, PI, Police Report, if available)

_____
_____
_____
_____
_____

Were you aware of the impending crash: ☐ Yes ☐ No

During the crash:
Did you strike any body parts in the vehicle? ☐ Yes ☐ No If yes describe _____
Did vehicle strike any objects after crash? ☐ Yes ☐ No If yes describe _____
Wearing hat or glasses? ☐Yes ☐ No If yes, still on after crash? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No If yes, for how long _____
Estimated property damage to your vehicle: $ _____
Estimated property damage to other vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

RELEASE OF INFORMATION

I _____, born _____ of
(Print Name) (Birthdate)

_____
(Address, City, State, and Zip Code)

authorize _____
(Name of Practice and/or Provider)

to release the following information from my medical record:

( ) History and Physical
( ) Consultation Report
( ) Progress Notes
( ) Rehab Progress Notes
( ) Other: _____

( ) Discharge Summary
( ) Laboratory Reports
( ) X-ray Reports

This information is to be sent to: **Moon Valley Chiropractic**
15420 N. 7th Street, Suite B
Phoenix, AZ 85022
_____ to provide continuum of care.

This authorization will be valid for the period of six (6) months and limited to the information I have requested above. I understand this information is confidential and may include information regarding drug/alcohol/HIV and/or AIDS related conditions. I understand that this information will not be further disclosed or used for any other purpose other than as stated in the authorization. I understand that I understand that I have the right to inspect and copy any written information to be disclosed and the right to revoke this consent at any time per written notice. I understand the requested copies for personal use will be subject to a reasonable fee.

_____ _____
Patient Date

_____ _____
Responsible Party Date

_____ _____
Witness Date

ASSIGNMENT OF BENEFITS
IN PERSONAL INJURY CASES

I authorize Moon Valley Chiropractic Clinic to receive lien payment from all liable insurance companies, attorneys, or myself for all monies due on my account. I understand that all coverage in effect at the time of my injury will be billed. Any over-payments will be promptly returned to me. In the event that there is no valid coverage or that I have exceeded my insurance limit, I will remain responsible for charges incurred.

Further, I hereby authorize Moon Valley Chiropractic Clinic or any of their employees to sign my name on the back of any draft or check which they receive for services rendered from my insurance company, whether pursuant to medical payments coverage or health insurance coverage, as long as I have an outstanding balance with them. Said amount shall be credited against my account and shall reduce my outstanding balance accordingly.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations. A complete list is available at the front desk.

Initial Consultation: No Charge. (Initial consultation does not include any exams or X-rays). X-ray services are subject to separate outside fees. All fees are subject to change without notice.

Any financial arrangements are to be determined prior to services rendered. I agree to the terms above and acknowledge that in the event that there is an outstanding balance which fails to be cured within sixty (60) days, my account with Moon Valley Chiropractic will be turned over to collection. I understand that should this happen, I will remain responsible for any and all additional collection fees and/or attorney and court costs.

Signature: _____ Date: _____