ARIZONA CHIROPRACTIC GROUP, MIONI DC

PREVENTION, WELLNESS AND INJURY CARE

Name:______________________________ Today's Date:______________
Address:____
City:______________ State:______________ Zip Code:______________
Home Phone:______________ Date of Birth:______________ SSN:______________
Name of Employer:______________________ Occupation:______________________
Employer's Address:____
Did you report this injury to your employer? Yes / No If yes, date reported:______________
Date of Injury:______________________ Time of Injury:______________________
Location of Injury:______________________ City/State:______________________
Describe the accident in your own words:____
____
____
____
____
Did you feel pain/symptoms immediately following the injury? Yes / No
Since the injury, are your symptoms ___Improving ___Getting Worse ___Staying the Same
What are your present symptoms?____
____
____
Did you seek medical attention immediately/soon after the accident? Yes / No
If yes, how did you get there? ___Drove ___Someone else drove you ___EMS/Police
FIRST DOCTOR/ HOSPITAL/ CLINIC SEEN:____
Were you examined? Yes / No
Were X-Rays taken? Yes / No
Were you given treatment? Yes / No If yes, what treatment was given and how often?______________
____
If treatment was given, what results did you receive?____
Date of last treatment, if applicable?____
Did you see any other doctor for this condition? Yes / No If yes, Please list:______________
____
Did you return to work immediately after the accident? Yes / No
Have you missed time from work? Yes / No If yes, give dates and dates hours:______________
____
____

WORKMAN'S COMPENSATION – SUPPLEMENTAL HISTORY

Have you been able to work since the accident? Yes / No

If no, date last worked: ____________________ If yes: Full Time / Part Time

Do any other conditions or injuries affect your employment? Yes / No If yes, please explain:______

____

____

Are your work activities restricted as a result of this injury? Yes / No If yes, please explain:______

____

____

Before your injury were you capable of working on an equal basis with others your age? Yes / No

Have you ever injured this area before? Yes / No If yes, please explain:_________________________

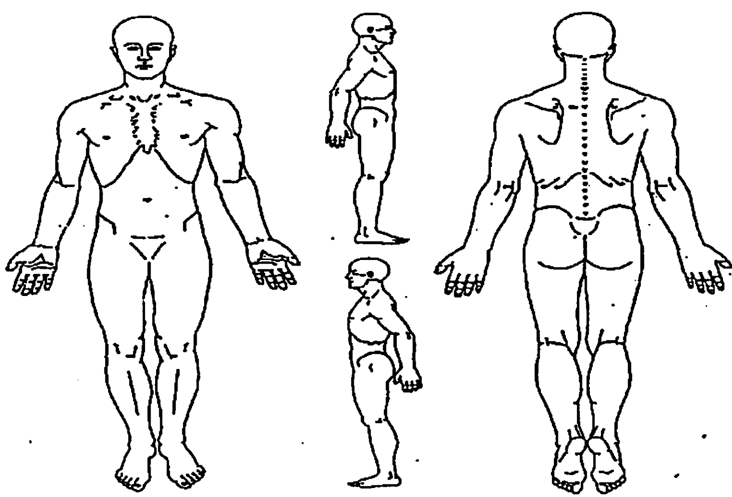
____

If injured before, did you lose time from work? Yes / No

PAIN DIAGRAM

Mark Area (s) of Concern

Circle Those That Apply



Ache

Spasm

Tenderness

Burning

Stabbing

Pain

Sharp

Dull Stiffness

Constant

Comes and Goes

Tingling

Numbness

Are you having any trouble doing any of the following activities?

(1= No restrictions, 2= Partially restricted, 3= Fully restricted)

___Lifting ___Standing ___Sitting ___Kneeling ___Bending

___Walking ___Sleeping ___Sleeping ___Personal Grooming

If you had to rate the pain or discomfort you are experiencing when it's at its **Worst,** what would you rate it?

(1 being no pain) **1 2 3 4 5 6 7 8 9 10** (10 being severe pain)

If you had to rate the pain or discomfort you are experiencing when it's at its **Best,** what would you rate it?

(1 being no pain) **1 2 3 4 5 6 7 8 9 10** (10 being severe pain)

Have you ever had a workman's Compensation claim before? Yes / No

If yes, name of insurance carrier:______________________________

Adjustor's Name:______________________________

Claim #:____________________ Phone#:____________________

Have you retained an attorney? Yes / No Litigation? Yes / No / Maybe

If yes, name address:______________________________

I authorize the release of any information required, and that my benefit payments be paid directly to Arizona Chiropractic Group, Mioni DC; however I understand that I am ultimately responsible for the payment of services. I sign below verifying that the information I have provided is true and correct to the best of my knowledge.

______________________________ ________________________

PATIENT SIGNATURE TODAY'S DATE

Thank you for completing this questionnaire regarding your work related injury. This information is needed for the doctor to evaluate your condition.

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:______________________ Last Name: ______________________

Email address: ____________________ @ __________________________

Preferred method of communication for patient reminders (Circle one): Email/Phone/Mail

DOB: __/__/__ Gender (Circle one): Male/ Female Preferred Language:________________

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / former Smoker / Never Smoked

Smoking start date (Optional): ________________

CMS requires providers to report race and ethnicity

Race (Circle one): American Indian or Alaska Native/ Asian /Black or African American /White (Caucasian)

Native Hawaiian or Pacific Islander / I decline to answer

Ethnicity (Circle one): Hispanic or Latino /Not Hispanic or Latino / I decline to answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name:	Dosage and Frequency (I.e.: 5mg once a day, ect)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I chose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature:__________________________________ date:______________

For office use only

Height: _______ Weight: _______ Blood Pressure:_______/ _______