ARIZONA CHIROPRACTIC GROUP

PREVENTION, WELLNESS, AND INJURY CARE

422 E. Southern Avenue • Tempe, Arizona 85282

SUPPLEMENTAL HISTORY/ AUTOMOBILE ACCIDENT INTAKE FORM

Name: _____ Date:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone: _____ Other Phone:_____
Date of Birth:_____ Social Security:_____
Employer:_____ Position:_____
I am: Single Married Widowed Other
How were you referred to our office? _____
Date of Injury:_____ Time of Injury:_____

You were the: **Driver/Passenger**

In the: **Front Seat/Back Seat**

How many vehicles were involved in the accident? _____
How many people were in your vehicle? _____
Was your car towed? _____

(Please circle all that apply):

Type of accident: **I was hit/ I hit someone else**

What direction were you headed? **North** **South** **East** **West**

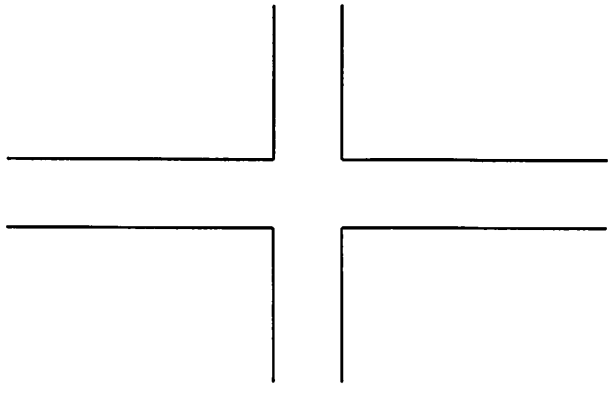
I was hit/hit from: **Behind** **Front**

Right **Left**

Stopped **Braking**

Visibility at the time of the accident: **Good** **Fair** **Poor**

Please indicate on the diagram how the accident happened:



Describe the accident in your own words:

_____

_____

_____

_____

Approximate damage done to the car you were in: $_____
Were you aware the accident was going to happen before impact? _____
Did you brace for impact? _____

Head position at impact: **Right** **Left**

Looking Back **Straight forward**

What (if any) parts of your body hit parts of your car during the accident?

_____

_____

Could you move all of your body parts after the accident? _____
Did you go to an ER or urgent care center following the accident?_____
Name of hospital/Urgent care:_____
Location:_____

<u>As a result of the accident were you:</u>
____Unconscious
____Dazed (Circumstances Vague)
____Shaken Up (But could function)

Have you suffered from memory loss since the accident?
Yes **No**
If yes, describe:_____

_____

Were you hospitalized?
Yes **No**
If yes, describe:_____

_____

Have you lost time from work as a result of this accident?
Yes **No**
If yes, describe, including dates:_____

_____

Before the accident did you have any of your present complaints?
Yes **No**
If yes, describe:_____

_____

Describe how you felt:
During the accident:_____
Immediately following the accident:_____
Later that day:_____
The next day:_____

Present Complaint: (Please check all that apply)

____Headache	___Pins and needles in arms/legs	___Extreme fatigue
___Head seems too heavy	___Chest pain	___Neuritis
___Head and shoulder tired	___Eyes strained/double vision	___Face flushed/pale
___Mental dullness	___Pain behind eyes	___Bowel trouble
___Equilibrium problems	___Eyes sensitive to light	___Digestive problems
___Palpitation	___Loss of taste	___Excess perspiration
___Neck pain/stiffness	___Loss of smell	___Difficulty lifting
___Neck motion restricted	___Sinus trouble	___Feet/hands cold
___Upper back pain/stiffness	___Extreme nervousness	___Difficulty breathing
___Mid back pain/stiffness	___Stiffness upon rising	___Anxiety
___Low back pain/stiffness	___Swollen:_____	

___Pain radiating into:_____
___Other, please list any other complaints:_____

Insurance Companies Involved:
Insurance company of party responsible for payment:_____
Claim #:_____ Phone:_____
Adjustor:_____ Policy #:_____
Name of insured:_____

Your automobile insurance company:_____
Claim #:_____ Phone:_____
Adjustor:_____ Policy #:_____
Do you have Med-Pay?: Yes No

Your group health insurance company:_____
Policy #:_____ Phone:_____

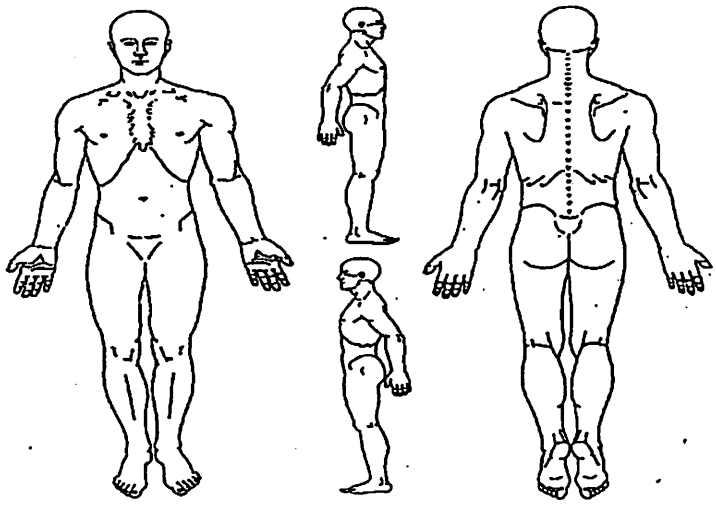
Have you retained and attorney? Yes No
Name of Attorney:_____
Name of Paralegal:_____
Firm Name:_____
Phone:_____

ARIZONA CHIROPRACTIC GROUP, MIONI DC

PREVENTION, WELLNESS AND INJURY CARE

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	___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)

I certify that this information is true and correct. I assign my benefit payments to be paid directly to Arizona Chiropractic Group, Mioni DC; however I understand that I am ultimately responsible for payment of services. I also authorize the release of any information which is required. Furthermore, I understand that Arizona Chiropractic Group, Mioni DC is not claiming to be a cure all for my symptoms.

_____ _____

PATIENT SIGNATURE TODAY'S DATE

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:_____/ _____