Pima Chiropractic Inc.
5806 E. Pima St. Tucson, AZ. 85712
520-722-1585

New Patient Intake and Accident Questionnaire ❶

Date: _____

Name: _____ Age: _____ Date of birth: _____
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 Conditions - Injuries - Symptoms:

Condition - Injury - Symptom	1.	2.	3.	4.
Date it began?				
In general, better with, when?				
In general, worse with, when?				
How would you describe the pain?	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other _____	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other _____	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other _____	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other _____
Does the pain or symptom radiate or go?	☐ yes ☐ no ☐ if yes, where? _____	☐ yes ☐ no ☐ if yes, where? _____	☐ yes ☐ no ☐ if yes, where? _____	☐ yes ☐ no ☐ if yes, where? _____
When awake - the pain/symptom is noticeable?	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%

Condition - Injury - Symptom	5.	6.	7.	8.
Date it began?				
In general, better with, when?				
In general, worse with, when?				
How would you describe the pain?	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other _____	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other _____	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other _____	☐ ache ☐ dull ☐ sharp ☐ stabbing ☐ throbbing ☐ other _____
Does the pain or symptom radiate or go?	☐ yes ☐ no ☐ if yes, where? _____	☐ yes ☐ no ☐ if yes, where? _____	☐ yes ☐ no ☐ if yes, where? _____	☐ yes ☐ no ☐ if yes, where? _____
When awake - the pain/symptom is noticeable?	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%	☐ >76% of the time ☐ 51-75% ☐ 26-50% ☐ <25%

Provider Initials: _____

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Patient Name: _____ Date: _____

IF NOT LISTED ABOVE, CHECK THE FOLLOWING SYMPTOMS NOTICED SINCE THE CRASH / ACCIDENT:

☐ *Headache*	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ringing*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ *Bruised Chest*	☐ *Radiating Pain*	☐ *Dizziness*
☐ *Sleep Disturbance*	☐ *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 (shoulder)	☐ Upper Leg Pain (hip)	☐ *Any Stitches*
☐ *Muscle Spasms*	☐ Lower Arm Pain (elbow/wrist)	☐ Lower Leg Pain (knee/ankle)	☐ *Any Cuts*
☐ *Fatigue*	☐ Other Symptoms: _____		

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

_____

_____

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

Was your head struck by the head restraint? ☐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)

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? _____

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

☐ Ice ☐ Medication (name) _____ ☐ Rest
☐ Heat (any kind) ☐ Exercise type _____ ☐ Other_____

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Patient Name: _____ Date: _____

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**

_____

_____

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? _____

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

Current Primary Care Physician:

_____

Name **Address** **Telephone**

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

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Patient Name: _____ Date: _____

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

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

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

3) AT-FAULT OR THIRD-PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

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

4) ATTORNEY: _____ Legal Assistant: _____

Address: _____

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

(If Applicable)

Have you had a repair estimate or has the vehicle you were in been repaired?

☐ Yes - If **Yes**, please provide a copy of the repair information
Was the repair done by an independent body shop? ☐ Yes ☐ No ☐ Not Sure
Did you get a second repair estimate? ☐ Yes ☐ No
Were the seatbelts replaced for all passengers in the crash? ☐ Yes ☐ No ☐ Not Sure
Were the anchors and seatbelt tensioners inspected for all passengers in the crash? ☐ Yes ☐ No ☐ Not Sure
Was there any damage to the seat(s) or head restraint(s)? ☐ Yes ☐ No ☐ Not Sure
Was the vehicle put on a hydraulic jack/lift? ☐ Yes ☐ No ☐ Not Sure
Was the frame inspected and/or repaired? ☐ Yes ☐ No ☐ Not Sure

☐ No - If **No**, when is it scheduled for repair? _____

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: _____

Provider Initials: _____

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SLEEP DISTURBANCE QUESTIONNAIRE

Patient Name: _____ Date: _____

Date of Injury: _____

How many hours of sleep do you normally need per night? _____

How many hours of sleep have you been getting per night? _____

List the hours you sleep on your: Back _____ Stomach _____ Right Side_____ Left Side _____

Circle the best answer:

Since Your Injury					
Do you have difficulty falling asleep?	Never	Rarely	Occasionally	Most Days/ Nights	Always
Do you have difficulty staying asleep?	Never	Rarely	Occasionally	Most Days/ Nights	Always
If you wake during the night do you have trouble getting back to sleep?	Never	Rarely	Occasionally	Most Days/ Nights	Always
Do you take anything to help you sleep?	Never	Rarely	Occasionally	Most Days/ Nights	Always
Does your sleep difficulty affect your ability to function through the day?	Never	Rarely	Occasionally	Most Days/ Nights	Always
Do you have to sleep at different times of the day?	Never	Rarely	Occasionally	Most Days/ Nights	Always

Any other sleep disturbance issues? _____

_____

_____

Patient Signature: _____

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Patient Name: _____ Date: _____/_____/_____

Duties Under Duress

How do your injury/injuries affect your performance of everyday and/or work activities?
Check the activities or duties that are painful or difficult for you to perform as a result of the injuries.
Also check the appropriate box designating reason for difficulty or limitation.

N/A Work Activity - Reason for the Difficulty/Limitation

☐ Lifting: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Bending: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Sitting: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Walking: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Computer Duties: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform

☐ I have experienced difficulty with my normal work activity for _____ weeks / months

N/A Studies/School - Reason for the Difficulty/Limitation

☐ Lifting: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Bending: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Sitting: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Walking: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Computer Duties: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Studying: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform

☐ I have experienced difficulty with my studies/school activity for _____ weeks / months

N/A Domestic Duties - Reason for the Difficulty/Limitation

☐ Vacuuming: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Taking Care of Children/Others: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Cleaning: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Laundry: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Preparing Meals: Increased Pain Restricted Movement Fatigue Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform

☐ I have experienced difficulty with my normal domestic duties for _____ weeks / months

N/A Household Duties - Reason for the Difficulty/Limitation

☐ Yardwork: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Transportation: ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Shopping: ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Taking Out Trash: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform

☐ I have experienced difficulty with my normal household duties for _____ weeks / months

Patient Signature: _____Date: _____/_____/_____

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Patient Name: _____ Date: _____/_____/_____

Loss of Enjoyment

Complete this form as it relates to activities you would usually enjoy, but are not as a result of your injury(s). Include those which you cannot do/perform and/or cannot do/perform as often as before your injury(s).

N/A Work Activity - Reason for the Difficulty/Limitation

☐ Lifting: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Bending: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Sitting: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Walking: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Computer Duties: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform

☐ I have experienced difficulty with my normal work activity for _____ weeks / months

N/A Studies/School - Reason for the Difficulty/Limitation

☐ Lifting: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Bending: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Sitting: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Walking: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Computer Duties: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Studying: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform

☐ I have experienced difficulty with my studies/school activity for _____ weeks / months

N/A Domestic Duties - Reason for the Difficulty/Limitation

☐ Vacuuming: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Taking Care of Children/Others: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Cleaning: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Laundry: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Preparing Meals: Increased Pain Restricted Movement Fatigue Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform

☐ I have experienced difficulty with my normal domestic duties for _____ weeks / months

N/A Household Duties - Reason for the Difficulty/Limitation

☐ Yardwork: ☐ Increased Pain ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Transportation: ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Shopping: ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Taking Out Trash: ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform
☐ Other: _____ ☐ Increased Pain/Anxiety ☐ Restricted Movement ☐ Fatigue ☐ Cannot Perform

☐ I have experienced difficulty with my normal household duties for _____ weeks / months

Patient Signature: _____ Date: _____/_____/_____

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Patient Name: _____ Date: _____/_____/_____

Loss of Enjoyment

N/A Sports - Reason for the Difficulty/Limitation

☐ Sport: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
Pre-Accident Level of Participation: ☐ Socially ☐ Competitively ☐ Professional
☐ Sport: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
Pre-Accident Level of Participation: ☐ Socially ☐ Competitively ☐ Professional
☐ Sport: _____ ☐ Increased Pain ☐ Restricted Movement ☐ Weakness ☐ Cannot Perform
Pre-Accident Level of Participation: ☐ Socially ☐ Competitively ☐ Professional

☐ I have experienced difficulty with my normal sports activity for _____ weeks / months

Patient Signature: _____Date: _____/_____/_____