Steven R. Harris, DC Chiropractic Physician
10516 W Peoria Ave. Sun City, AZ 85351 Phone: (623)-972-9223

Patient Name:_____ Date:____/_____/_____
First Last MI

Initial Symptoms By Area

Check any of the following if you are experiencing any Pain, Numbness, Tingling, Loss of feeling or weakness. Describe.

- ☐ Headache Front Back Side: L R B _____
- ☐ Jaw Pain L R B _____
- ☐ Neck Pain L R B _____
- ☐ Top of Shoulder pain L R B _____
- ☐ Shoulder Pain L R B _____
  - ☐ Arm Pain L R B _____
  - ☐ Elbow Pain L R B _____
  - ☐ Wrist Pain L R B _____
  - ☐ Hand Pain L R B _____
- ☐ Upper Back Pain L R C _____
- ☐ Mid Back Pain L R C _____
- ☐ Low Back Pain L R C _____
- ☐ Buttock Pain L R B _____
- ☐ Thigh Pain L R B _____
- ☐ Hip Pain L R B _____
- ☐ Groin Pain L R B _____
- ☐ Knee Pain L R B _____
  - ☐ Calf Pain L R B _____
  - ☐ Ankle Pain L R B _____
  - ☐ Foot Pain L R B _____

Other Symptoms:_____

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

☐ Headache ☐Bruised Chest ☐ *Ears Ring* ☐ Lower Leg Pain ☐ *Any Cuts* ☐ Muscle Spasms ☐ Lower Arm Pain
☐ Chest Pain ☐ Lower Back Stiffness ☐ *Buzzing in Ears* ☐ Sleeping Problems ☐ Bruising Anywhere
☐Tingling in Legs ☐ Loss of Smell ☐ Neck Stiffness ☐Nervousness ☐ Radiating Pain ☐*Shortness of Breath*
☐Constipation ☐Irritability ☐ Black and Blue ☐Fatigue ☐ *Anxiety* ☐ Sensitivity to Light ☐ *Depression* ☐ *Blurred Vision*
☐ Tingling in Arms ☐ Loss of Taste ☐ Jaw Pain ☐ *Any Burns* ☐ *Fainting* ☐ Upper Arm Pain ☐ Anxiousness
☐ Upper Leg Pain ☐ *Any Stitches* ☐ *Nausea* ☐*Tension* ☐ Muscle Aches ☐Diarrhea ☐ *Dizziness*

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?: (Circle all that apply)

☐ Tuberculosis ☐Lung Disease ☐ Gout ☐ Diabetes ☐ Colon Disease ☐ Stroke Cancer ☐ Bleeding ☐ Kidney
☐Disease ☐ Stomach/Ulcer ☐ Heart Disease ☐ Hepatitis ☐ Sciatica ☐ Blood Pressure ☐ Transfusion ☐AIDS
☐ Polio / MS ☐ Paralysis ☐ Seizures ☐ Arthritis ☐ Asthma ☐ Anemia ☐ Thyroid Disease ☐ Drug Dependence

Patient Signature_____

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Patient Name_____ Date _____

Since your accident on _____ (date) have you noticed or experienced any of the following:

Headaches: ☐ Yes ☐ No If yes, please describe:_____

_____

Anxiety: ☐ Yes ☐ No If yes, please describe:_____

_____

Depression: ☐ Yes ☐ No If yes, please describe:_____

_____

Visual impairment or difficulties: ☐ Yes ☐ No If yes, please describe:_____

_____

Muscle spasms: ☐ Yes ☐ No If yes, please describe:_____

_____

Jaw pain: ☐ Yes ☐ No If yes, please describe:_____

_____

Ringing in your ears: ☐ Yes ☐ No If yes, please describe:_____

_____

Restricted movement or motion in your joints: ☐ Yes ☐ No If yes, please describe:

_____

_____

Tingling, numbness or radiating pain: ☐ Yes ☐ No If yes, please describe:_____

_____

Any impairment of activity or disabilities: ☐ Yes ☐ No If yes, please describe:_____

_____

_____
Patient Signature

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Patient Name:_____ Date:_____/_____/_____
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Insurance Information

Date of Impact: ____/___/_____

At Fault Insurance Company:_____ Claim #_____
Address:_____ City:_____ State:____ Zip:_____
Policy #:_____ Insurance Phone:_____
Primary Insured:_____ Relationship to driver:_____
****

Pt's Health Insurance Company:_____ ID#_____
Primary Insured:_____ Relationship:_____
Primary's Date of Birth:_____/_____/_____ Employer:_____
Insurance address: _____Insurance Phone:_____

Your Car Insurance Company:_____ Phone :_____
Address:_____ City:_____ State:____ Zip:_____
Claim Number:_____ or Policy #:_____
Insured Name:_____ Adjusters Name:_____

Other Health Policy information: Insured Name:_____ Relationship _____
Insurance company_____
Ins. Address:_____City:_____ State:____ Zip:_____
Phone Number:_____ ID#_____
****

Have you retained an attorney: Yes____ No____ If so: Office Name:_____
Are you considering retaining an attorney? Yes No
Attorney Name:_____ Phone:_____
First Last
Legal Assistant if known:_____

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First name:_____ Middle initial:_____ Last name_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work: _____ Cell:_____

Preferred Contact method:_____ Secondary:_____

Employed by:_____

Emergency Contact name and phone number:_____

Social Security:_____- _____-_____ Date of Birth:_____/____/_____ Dominant Hand: ☐Left ☐Right

Marital Status: Single Widow(er) Divorced Separated Married Live with unmarried partner
Spouse's / Partner's first name:_____ Their Last name: _____

Are you a full or part time student? Yes___\ No___ Are you living with a relative? Yes___\ No___

Automobile Crash Information

Date of Impact: ____/___/_____ **Time of Impact**:_____:_____ AM PM

Street where accident happened:_____City:_____

State:_____ Cross Streets:_____ Did accident happen on a freeway: Y/N

What Freeway:_____ What police department investigated the accident:_____

Did anyone receive a ticket from the accident: Yes___ \ No___ If so, who_____

Was an accident report filled out by the police? Yes___ No___

Did you receive a card with other driver's information from the police: Yes ___ \No____

Did other driver's insurance company accept liability: Yes_____ No_____ What %? _____

Description of Crash

Please answer the questions below. If you don't know the answer to any of the questions, DO NOT answer that question

1. Your vehicle type: ☐ Car ☐SUV ☐VAN ☐ Pickup Truck ☐Large Truck ☐ Motorcycle Other_____
   Make:_____ Model: _____ Year:_____

2. Your Position in the vehicle: ☐ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐Right Rear Passenger
   ☐ Van passenger **Motorcycle Only**: ☐ Driver ☐ Passenger ☐Side Car
3. What was your vehicle doing at the time of the accident? Please circle all correct of the following**:**
   Stopped at intersection Stopped in traffic Stopped at light Proceeding along Slowing down
   Accelerating Making a right turn Making a left turn Other:_____
4. How many vehicles were involved in the accident? (circle) 1 2 3 more

5. Your Vehicle Speed :_____ mph Their Vehicles speed_____ mph
   Damage to your vehicle: ___ Mild ___ Moderate ___Severe Was your vehicle towed? Yes__\ No__
   Damage to their vehicle: ___ Mild ___ Moderate ___Severe Was their vehicle towed? Yes__\ No__
   Make: _____ Model:_____ Year :_____

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6. Road conditions at time of accident: ___ Icy ___Wet ___Sandy ___Clean and dry
Your vehicle's visibility at time of accident: ___ Poor ___Fair ___Good ___Dark
Your vehicle's estimated damage if known?_____

Point of impact PLEASE CHECK ALL THAT APPLY:

Other vehicle hit you on: Rear-End____ Left Rear____ Right Rear____ Head-On____ Left Front___
Right Front____ Left Side____ Right Side____ **Motorcycle Only**: ___Left side ____ Right side
You hit other vehicle on: Rear-End____ Left Rear____ Right Rear____ Head-On____ Left Front___
Right Front____ Left Side____ Right Side____ **Motorcycle Only**: ___Left side ____ Right side

Motorcycle Only: ___Left side ____ Right side

7. Body Position, etc. **Please answer all questions by checking YES or NO**
Does your vehicle have headrests? Yes___ \ No____ Did you see the accident coming? Yes____\ No____
Did you have a seatbelt on? Yes___ \ No____

Was your shoulder harness on? Yes____\ No____ Did driver airbag deploy ? Yes___ \ No____
Did passenger airbag deploy? Yes___\ No____ Did any side airbag deploy? Yes____ \No____
Were you aware of the coming crash? Yes__\ No__
What position was your headrest at the time of the impact? ☐ Even with the top of head
☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at impact? ☐ Turned to the right ☐ Turned to the left
☐ Facing straight forward Other _____
Motorcycle Only: Were you wearing a helmet? Yes___\ No___

8. During the Accident:
Did your body strike inside of your vehicle? Yes____\ No____ If yes, describe:_____
Did your head or shoulder hit the door or window or any part of your vehicle (including the head-rest)?
Yes___\No___
Did your knees hit the dash or door? Yes___ \ No____ If so which side(s)_____
Did any other part of your body strike against any part of the vehicle? Yes___\ No___ If yes please explain:____
_____
Did you hear the sound of breaks or horn? Yes___ \ No__ Did driver side airbag deploy? Yes___ \ No____
Did passenger side airbag deploy? Yes___\ No____ Side Air bags? Yes____ \No_
Were you engaged in movement or changing position at the time of the impact t? Yes___ \ No____
Were you aware of the coming crash? Yes__\ No____ If Yes were you tensed up and bracing for impact?_____
Were you relaxed in your seat prior to the impending crash? _____
Are there any other factors involved in causing your injuries?_____

9. Did you lose consciousness during the impact? Yes___/No___ If yes, for how long?_____
10. Treatment History: Where did you go right after the accident?
☐ Home ☐ Urgent care ☐ Hospital ☐ Other _____
How did you get there ? ☐ Self ☐ Somebody else ☐ Ambulance ☐ Police Other _____
Were you admitted to the hospital? Yes No If so, where and for how long? _____
If treated at an ER or Urgent care: indicate the care received: X-rays of body area(s)_____
MRI or CT Scan of body area(s)_____ Did you receive pain medication Yes No
Other medications prescribed:_____

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Other types of treatments received: (Circle all that apply)
Cervical collar Ice instruction Was blood drawn?_____
Did you self treat your symptoms at home? Yes No If so indicate how: Over the counter medication _____, Ice packs _____, old prescription medication ____, Heat ____, Bed Rest _____, Muscle creams _____, Exercise/stretching _____, Other:_____.
Anything else the doctor should know_____.

11. Check off your symptoms, including pain in the following areas, since the accident.

If you had a problem in that area prior to the accident, check the area, we will separate them later.

Headache	Nausea	Dizziness	Fainting	Nervousness	Anxious	Tension
Tingling in arms/legs	Ringing in the ears	Shortness of breath	Sleeping Problems	Low Back Pain	Neck Pain	Neck Stiffness
Fatigue	Mid Back Pain	Feet/Toes	Leg pain	Knee pain	Ankle pain	Buttock pain
Hip pain	Thigh pain	Hands/fingers	Elbows/forearms	Arm pain	Shoulders	Diarrhea
Constipation	Depression	Chest Pain	Loss of Smell	Loss of taste	Pain behind eyes	Confusion
Bruising	Lacerations	Muscle Aches	Irritability	Jaw/TMJ	Other	Other

X_____ _____/_____/_____
Patient Signature Date

X Name printed _____

X _____
Witness \ Staff member

Harris Chiropractic PLC

10516 W Peoria Ave. Sun City, AZ 85351

PHONE: 623-972-9223 FAX: 623-977-5762

ACKNOWLEDGMENT OF HIPAA PRIVACY NOTICE

I, _____, have the opportunity to receive a copy of this office's HIPAA Notice of Privacy Practices.

I understand that I have certain rights to privacy regarding my protected health information. I understand that my information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers and conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **The patient refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**