NEW PATIENT HEALTH QUESTIONAIRRE (Auto Accident)

New Smyrna Beach Chiropractic Clinic, PLC

Date:__________________ Patient's Name:_________________________________
SSN:______________________ Sex: M F Age:_____ Birth Date (MM/DD/YYYY):_____________
Height: ______________ Weight:________________ O Right Handed O Left Handed

Home Address (Street, City, Postal Code):____
____

Telephone: Home: _____________ Bus:_____________ Cell:_______________ **Email Address:**_______________

INSURANCE INFO: CO. Name:_______________________ Address:______________________________________
Phone #:____________________ Group#:_____________________ Insured's Name:_________________________
Relation:___________________ DOB:________________ Insured's Employer:_______________________________

Referred By:________________________________

Have you ever had previous chiropractic care? Y N If so when:_____________ With Whom?___________________

Primary Care Physician:___________________ Office Phone Number:______________ Date of Last Visit:________

Are there recent X-Rays, MRI's, or CT Scans available? Y N
Date Taken?____________________________ Where?________________________________

ABOUT YOUR PAIN:

- Date pain started? ________________ How did it occur?_______________________________________
- Where does it hurt?_____________________________ Have you ever had this before? Y N when?________________
- Is the problem getting: O worse O no change O better
- Any pain at night? Y N Does coughing, sneezing or straining aggravate the pain? Y N

How would your rate the pain?
1 = I feel no pain 10 = I hurt so bad I could go to the hospital
1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY:
Have you ever: (Be as accurate as possible)

- Had an accident (car, fall, sports, other)? Y N
  - If Yes, please tell us about it:____
- Had an operation? Y N Describe (WITH DATES):____
- Been hospitalized? Y N Describe (WITH DATES):____
- Major Illness? Y N Describe (WITH DATES):____

Please list any and all medication or herbal supplements and reason for taking:_______________________________
____

FAMILY HISTORY:
Do you have any family history in your mother, father, siblings or grandparents of BACK PAIN, HEADACHES, CANCER, DIABETES, STROKE, ARTHRITIS OR HEART DISEASE? Y N Please list conditions not mentioned:______________________________

If yes: Who?_____________________What conditions?_____________________Age Deceased?_____________________

SOCIAL HISTORY:
Smoke? Y N pks/day?_______________ Alcohol? Y N drinks/day?________________
Exercise? Y N times/wk?____________________Sleep___________hrs/day on: O back O left side O right side O stomach
How would you describe your stress level? O minimal O moderate Osevere O intolerable

Health History Questionnaire (PLEASE MARK ALL PAST/PRESENT CONDITIONS AS THIS SECTION IS VERY IMPORTANT)

Please **circle** any conditions you <u>currently</u> have and place an **"X"** on the line if you have had this condition in the <u>past.</u>

General

___Chronic Fever
___ Chills
___ Night Sweats
___ Loss of Sleep
___ Chronic Fatigue
___ Nervousness
___ **Weight Loss/Gain**
___ Allergies
___ Bleeding Problems
___ Anemia
___ **Diabetes**
___ **Cancer**
___ Thyroid Disease
___ **High Cholesterol**
___ **Osteoporosis**
___ Alcoholism
___ Drug Abuse

Cardiovascular

___ Irregular Heartbeat
___ **High Blood Pressure**
___ Pain in Chest
___ **Heart Disease**
___ Ankle Swelling
___ Varicose Veins
___ **Stroke**
___ **Heart Attack**
___ Heart Murmur

Eyes, Ears, Nose, Throat

___ Poor Vision
___ Pain in eye(s)
___ Deafness/Difficulty hearing
___ Nosebleeds
___ Nose Problems
___ Sinus Problems
___ Hoarsness
___ Difficulty Swallowing
___ Dental Problems
___ Reccurent Ear Infection

Genitourinary

___ Frequent Urination
___ Painful Urination
___ **Blood in Urine**
___ Urinary Infection
___ **Kidney Disease**
___ **Inability to Control Urine**
___ **Difficulty Starting Urine Flow**
___ Frequent Night Urination
___ Breat Lumps or Pain
___ Venereal Disease
___ Sexual Dysfuntion
___ Kidney Stones

GastroIntestinal

___ Poor Appetite
___ Poor Digestion
___ Belching or Gas
___ Chronic Nausea
___ Vomiting Blood
___ Pain over Abdomen
___ Ulcer
___ Black or Bloody Stool
___ **Liver Problems**
___ Gallbladder Problems
___ Jaundice
___ Hernia
___ Chronic Diarrhea
___ Chronic Constipation
___ Hemorrhoids
___ Appendicitis

Skin

___ Itchy/Dry/Flaky
___ Bruise Easily
___ Change in Mole
___ Skin Cancer
___ Rashes
___ Abnormal Scars
___ Inability to stop bleeding

Respiratory

___ **Difficulty Breathing**
___ Chronic Cough
___ Coughing up Phlegm
___ Coughing up Blood
___ **COPD**
___ Asthma
___ Pneumonia
___ Tuberculosis
___ **Emphysema**

<u>Male Only</u>

___ Testicular Swelling
___ **Prostate Problems**
___ Undescended Testicle
___ Painful Intercourse

Neurological

___ **Weakness**
___ Twitching
___ Tremors
___ Chronic Headaches
___ Fainting
___ Dizziness
___ Convulsions
___ **Epilepsy**
___ **Numbness/Tingling**
___ Arm/Leg Pain
___ Mental Disorder

Musculoskeletal

___ Neck Stiffness/Pain
___ Pain between shoulder blades
___ Low Back Pain
___ Swollen Joints
___ Stiff/Painful Joints
___ Muscle Aches/Sorness
___ Spinal Curvature
___ Arthritis
___ Knee Pain
___ Shoulder Pain
___ Wrist/Hand Pain
___ Ankle/Foot Pain
___ **Radiating Pain into Arms**
___ **Radiating Pain into Legs**
___ **Disc Herniation**
___ Disc Bulge

Habits/Exercise

___ Smoking ___pks/day
___ Alcohol ___drinks/wk
___ Recreational Drug Use
___ Exercise _____ times/wk
___ Caffeinated drinks __ drinks/day
___ Water _____ cups/day

Other

___ Memory Loss
___ Concentration Loss
___ Convulsions
___ Vertigo
___ Chronic Fatigue
___ Osteoporosis
___ Fibromyalgia
___ Aneurysm
___ **HIV/AIDS**
___ **Fibromyalgia**
___ **Recent *<u>UNITENTIONAL</u>* weight loss**

Please list all other past medical diagnosis: ____

<u>WOMEN ONLY:</u>

O excessive menstruation
O irregular cycle
O hot flashes
O **breast pain/lumps**
O painful menstration
O painful intercourse
O other___________________________

ANY CHANCE YOU ARE PREGNANT? Y N HOW MANY MONTHS?_________

LAST DAY OF LAST MENSTRAL CYCLE?______________________ DATE OF LAST PAP TEST?__________________________

ABOUT YOUR ACCIDENT:

Date & Time of Accident:____

Were you the: O Driver O Front Passenger O Rear Passenger on **Left** side or **Right** side Make and Model vehicle:_____________

If a traffic violation was issued, to whom was it issued?____

Number of people in accident vehicle? _____ Are they currently seeking care and with who?____________________________

Did the police come to the accident site? O Yes O No Was a police report filed? O Yes O No Where there witnesses? O Yes O No

Were you wearing a seat belt? O Yes O No Was the vehicle equipped with airbags? O Yes O No If yes, did it/they inflate? O Yes O No

In relation to the base of your skull, where was the headrest? O Above O Below O At base of skull

What did your vehicle impact? O Other vehicle O Other ____

Did any part of your body strike anything in the vehicle? O Yes O No

If yes, please describe:____

Street on which you were traveling?______________In which direction were you headed? O N O S O E O W

Where you at a complete stop? Y N If you were not at a complete stop how fast were you traveling?_______________mph

Did the impact to your vehicle come from the: O Front O Rear O Right side O Left side O Other

During impact, were you looking: O Right O Left O Forward O In rear view mirror

On impact were you: O aware O surprised **AND** O braced O not braced

If another vehicle was involved, what was the make and model?___________________________________

Direction of other vehicle? O N O S O E O W What was the speed of other vehicle?_____ mph

Describe the accident in your own words:____

____

After Impact:

After the accident did you experience: O Loss of Consciousness O Dizziness O Dazed O other____________________

Have you gone to a Hospital or seen any other Doctor? O Yes O No

Name of Hospital and/or Attending Doctor:____

When did you go? O Immediately O Next day O 2 Days O other:______________________________

Transportation? O Ambulance O Private Vehicle

Describe any treatment you received?____

Were X-rays taken? Y N If yes, of what areas?_____________Were MRI's or CT scans taken? Y N If yes, of what areas?_______

Was medication prescribed? O Yes O No If yes, name and dose of medication_______________________________________

Have you returned to work since the accident? O Yes O No

Are your work activities restricted as a result of this injury? O Yes O No

Do you have any (from the accident): O Bruises O Cuts O Broken Bones O Rashes O NONE

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day?________

Prior to the injury were capable of working on an equal basis with others our age? O Yes O No O N/A

While in recovery, is there any light duty work you could request? O Yes O No O N/A

Please indicate with checkmarks your daily job duties and any activities which you are occasionally asked to perform.

O Standing O Driving O Operating equipment O Sitting O Twisting

O Walking O Crawling O Typing O Lifting O Bending

O Stooping O Work with arms above your head O Other

Indicate with a check mark the symptoms that are a result of this accident:

O Dizziness O Difficulty sleeping O Jaw problems O Nausea O Memory loss

O Irritability O Arms/ shoulder pain O Back pain O Headache(s) O Fatigue

O Numb hands/ fingers O Lower back pain O Blurred vision O Tension

O Chest pain O Back stiffness O Buzzing in ear O Neck pain O Shortness of breath

O Leg pain O Ears ringing O Neck stiff O Stomach upset O Numb feet/ toes O Other__________________

Is your condition getting worse? O Yes O No O Constant O Comes & goes

Have you retained an attorney? O Yes O No If yes, whom?_________________ Phone #___________

Indicate your degree of comfort while performing the following activities: (even if only sometimes)

	Comfortable	Uncomfortable	Painful		Comfortable	Uncomfortable	Painful
Lying on back	O	O	O	Lying on side	O	O	O
Lying on stomach	O	O	O	Sitting	O	O	O
Standing	O	O	O	Stretching	O	O	O
Sexual Intercourse	O	O	O	Walking	O	O	O
Running	O	O	O	Sports	O	O	O
Working	O	O	O	Lifting	O	O	O
Bending	O	O	O	Kneeling	O	O	O
Pulling	O	O	O	Reaching	O	O	O

My Healthcare Benefits:

I fully understand when the insurance company verifies my benefits **IT IS NOT A GUARANTEE OR AUTHORIZATION TO PAY ON CLAIMS SUBMITTED.** I agree to pay my patient portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay/settle any denied and unpaid claim. I further understand all claims submitted by this office are my responsibility and require my participation to settle regardless of my insurance company or assignment of benefits.

_________________________________ ____/____/____
Signature of Patient or Parent/Guardian Date

Treatment Authorization and Assignment of Benefits:

This office has my permission to copy my driver's license or photo ID for the sole purpose of identification and verification. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the release of any medical information necessary to process and to secure payment of benefits. I authorize payment directly to New Smyrna Beach Chiropractic Clinic, PLC/ Dr. Amanda Prokop, D.C. of the "Health Benefits", "Medical Reimbursement" from a Third Party Payer and/or "Government Benefits" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly. Should collection of past due amount become necessary, I will become responsible for all charges, fees, and attorney fees. I authorize the use of this signature on all insurance submissions and I certify my sole purpose of entering this office is for healthcare.

_________________________________ ____/____/____
Signature of Patient or Parent/Guardian Date

Consent to Treat a Minor:

I (we) being the parents, guardian, or custodian of the minor being ______________________, Age____________, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgement is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

_________________________________ ____/____/____
Signature of Patient or Parent/Guardian Date

I have completed the above information to the best of my knowledge. I authorize New Smyrna Beach Chiropractic Clinic, PLC to release any information concerning my health and health care services to my insurance companies. I hereby assign all medical benefits to which I am entitled, private insurance, Medicare, and any other insurance program to New Smyrna Beach Chiropractic Clinic, PLC and I direct that payment be made directly New Smyrna Beach Chiropractic Clinic 665 N. Dixie Freeway New Smyrna Beach, FL 32168. A photocopy of this assignment is to be considered as valid as original. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges, whether or not paid/covered by said insurance, and that I will be responsible for any amounts uncollected by New Smyrna Beach Chiropractic Clinic, PLC.

_________________________________ ____/____/____
Signature of Patient or Parent/Guardian Date
New Smyrna Beach Chiropractic Clinic, PLC