WEBSTER FAMILY CHIROPRACTIC
16515 S. 40th Street, Suite 103 Phoenix, AZ. 85048
T (480) 785-1351 F (480) 785-1647

INITIAL DOCTOR-NEW PATIENT HISTORY FORM ❶

Patient: _____ Age: _____ Birth Date: _____

Time In: _____ Time Out: _____ Date of Accident: _____

Doctor: _____ Date Of Exam: _____

Sex: ☐ M ☐ F Marital Status: _____ Spouse Name: _____ # of Children: _____

Occupation: _____ Years: _____ Employer: _____

Are you or have you missed time from work? ☐Yes ☐ No Type of Work: ☐ Office ☐ Clerical ☐ Light ☐ Moderate ☐ Heavy Labor

Describe the type of work performed: _____

Were you on-the-job when the accident occurred? ☐ Yes ☐ No

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Rear Seat Passenger ☐ Other _____

Vehicle was driven by: _____

Did your vehicle strike another vehicle? ☐ Yes ☐ No Did another vehicle strike your vehicle? ☐ Yes ☐ No

Were you struck from: ☐ Behind ☐ Front ☐ Driver's side ☐ Passenger's side ☐ other _____

Were traffic citations issued? To whom? ☐ You ☐ Driver of your vehicle ☐ Driver of other vehicle ☐ None

Were police at the scene? ☐ Yes ☐ No If yes, was a report made? ☐ Yes ☐ No Did accident occur on ☐ public or ☐ private property

Your vehicle was heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/highway)

The other car heading: ☐ North ☐ South ☐ East ☐ West on _____ (Street/highway)

Your Vehicle (Year, Make, Model): _____

Your speed at the moment of accident: ☐ Full Stop ☐ Slowing ☐ Accelerating ☐ Legal Limit

The other Vehicle (Year, Make, Model) _____

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other _____

Head restraints: ☐ None ☐ Integral Type ☐ Adjustable: ☐ Up ☐ Down ☐ Don't know

If adjustable, was the position altered by the accident? ☐ Yes ☐ No

Was the seat back adjustment altered by the accident? ☐ Yes ☐ No

Type of Restraints: _____

Did air bag deploy? ☐ Yes ☐ No If Yes, were you struck by airbag? ☐ Yes ☐ No Were you burned? ☐ Yes ☐ No

Body position: _____ Head position: ☐ Forward ☐ Left _____° ☐ Right _____° ☐ Up _____° ☐ Down _____°

Position of Hands: ☐ One on steering wheel ☐ Two on steering wheel ☐ N/A Were brakes applied at impact? ☐ Yes ☐ No

Dr. Initials: _____

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Patient: _____

Accident Description: (How did the accident happen?) _____

_____

_____

Were you aware of impending crash?: ☐ Yes ☐ No

Did your body hit any part of your vehicle? ☐ Yes ☐ No If yes, describe _____

Did anything inside the vehicle strike you? ☐ Yes ☐ No If yes, describe _____

Did your vehicle hit any other object after the crash? ☐ Yes ☐ No If yes, describe _____

Were you wearing a hat or eye or sunglasses? ☐Yes ☐ No If yes, were they still on after crash? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No If yes, for how long _____

Estimated damage to your vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Estimated damage to other vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Since the crash, tell me **ALL** symptoms or injuries you have experienced and specifically when each began: _____

_____

_____

Where did you go after accident? ☐ Hospital ☐ Urgent Care ☐ Family Provider ☐ Home ☐ Work ☐ Other_____

Emergency Room Treatment:

Were you seen in the ER: ☐ Yes ☐ No Which hospital: _____ Were taken by ambulance? ☐ Yes ☐ No

Date seen if not taken by ambulance _____

Was treatment given? ☐ Yes ☐ No If yes, X-rays: ☐ Yes ☐ If yes, which body parts x-rayed _____

Results of X-rays: _____ Lab work ☐ Yes ☐ No Results: _____

Cervical collar ☐Yes ☐No Ice ☐ Yes ☐ No Medication: ☐ Yes ☐ No If yes, name of Rx: _____

Other treatment: _____ Follow-up Instructions: _____ ☐ None

Work restriction ☐ Yes ☐ No If yes, describe_____

Other Treatment Since Crash #1:

Doctor: _____ Specialty: _____ Date first seen: _____

Referred by: _____ Treatment type: _____ Treatment frequency: _____

Treatment duration: _____ Currently treating? ☐ Yes ☐ No

Work restriction ☐ Yes ☐ No If yes, describe_____

Special tests: _____ Referred to: _____

Did treatment help? ☐ Yes ☐ No Comments: _____

Dr. Initials: _____

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New Patient Registration and Accident Questionnaire ❶

Name: _____ Age: _____ Date of birth: _____ Date: _____
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 Symptoms: 1._____ 2._____ 3._____ 4._____

5. _____ 6. _____ 7. _____ 8. _____

When did your symptoms begin? _____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

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

_____

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? _____

Please list all serious illness and serious accidents:	**Month and Year**	**City, State**

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Patient's Name: _____ Date: _____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

_____

_____

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

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)

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

☐ *Headache*	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ *Bruised Chest*	☐ *Radiating Pain*	☐ *Dizziness*
☐ *Sleep Disruption*	☐ *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	☐ Upper Leg Pain	☐ *Any Stitches*
☐ *Muscle Spasms*	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

☐ Other Symptoms: _____

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 ☐ Other_____

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Patient's Name: _____ Date: _____

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

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

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

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

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

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____ Policy #: _____ Insured: _____

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

4) ATTORNEY: _____ Legal Assistant: _____

Address: _____

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

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: _____

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PERSONAL AFFECTS QUESTIONNAIRE ❷

We want to make sure and understand any of the personal consequences that this accident/collision has caused. Please complete and return to us at your convenience.

Patient Name: _____ Date: _____

Date of Injury: _____

The accident/collision has affected me physically as follows: _____

_____

_____

_____

_____

_____

The accident/collision has affected me emotionally as follows: _____

_____

_____

_____

_____

_____

The accident/collision has affected me financially as follows: _____

_____

_____

_____

_____

_____

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Patient Name: _____ Date: _____

The accident/collision has affected my relationship with my family as follows: _____

The accident/collision has affected me at work as follows: _____

The accident/collision has affected my home activities as follows: _____

The accident/collision has affected my hobbies as follows: _____

Patient Signature: _____ Date: _____

DIAGNOSTIC X-RAY CONSULTATION SERVICES®

GARY A. LONGMUIR, M.App.Sc., D.C., D.A.C.B.R.
Radiology

Diplomate, American Chiropractic Board of Radiology
Fellow, the American Chiropractic College of Radiology

2525 West Carefree Highway, Building 2A. Suite 114
Phoenix, AZ 85085-9302
Telephone: (602) 274-3331
Fax: (602) 279-4445
www.diagnostictx-ray.com

PATIENT AUTHORIZATION AND ASSIGNMENT

I consent that my x-rays will be interpreted by Dr. Gary A. Longmuir, chiropractic radiologist, and that a formal written report will be issued to my physician's office to become part of my permanent treatment record. I understand that all charges from this consultation are ultimately my responsibility and separate from any charges at my Physician's office.

I authorize the release of any medical information necessary to process this claim. I also authorize the direct payment of medical benefits from group health, medical payments or third party payor to the physician for services described above. In the event that payment is not made on this account and it is placed with a licensed collection agency, I agree to pay collection agency fees up to a maximum of 21% of the outstanding balance at the time the account is placed with the agency. Should legal action be necessary to collect the account, I agree to pay attorney's fees and court cost incurred for collection.

Date_____ **Patient's Signature** _____
(Parent or guardian if minor child)

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize this doctor's office to furnish you, my attorney, with a full report of the x-ray examination of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by said doctor for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor's awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Dated_____ **Patient's Signature**_____
(Parent or guardian if minor child)

Patient's Name_____
(Please print)

The undersigned being attorney of record for the above patient does hereby agrees to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said doctor named above.

Dated_____ **Attorney's Signature**_____

Please date, sign and return one copy to doctor's office.

Keep a copy for your records. A photocopy of this form shall be considered as valid as the original.