Arcadia Spinal Health Center Doctor's Name: Gregg Friedman, DC, CCSP, FIACA

Patient's Name: _____ Today's Date: _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

Were you wearing a seatbelt? **Yes / No** What type: **Lap Belt / Shoulder Belt / Both**

What was your position in the car? (Circle) **Driver / Front Passenger / Left Rear / Right Rear**

If "Driver", were your hands on the steering wheel? **Both / Left / Right**

What was the year, make and model of vehicle were you in? _____

Direction of Impact: **Front / Back / Left / Right / Other:** _____

What was the year, make and model of the other vehicle? _____

What was the approximate speed of **your vehicle** when the accident occurred? _____ mph

What was the approximate speed of the **other vehicle** when the accident occurred? _____ mph

Did the airbags deploy? **Yes / No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike another vehicle? **Yes / No** Did another vehicle strike your vehicle? **Yes / No**

If Second Collision – Angle of 2nd impact: **Front / Back / Left / Right / Other:** _____

In relation to the back of your head, was your headrest set: **Low / Middle / High**

Were you surprised by the impact? **Yes / No** If "NO", how did you brace? **With Hands / With Feet**

Where was your head facing at the time of impact? **Straight Ahead/ Left/ Right/ Behind/ Inclined**

Were you leaning forward at the time of impact? **Yes / No**

Did you feel pain immediately after the accident? **Yes / No** If yes, where? _____

Patient's Name: _____ Today's Date: _____

Did you strike anything in the vehicle at the time of impact? **Yes / No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

Did your seat break or bend? **Yes / No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy / Dazed / Weak / Upset / Disoriented / Nervous / Nauseous / Other:** _____

Police and Ambulance:

Was the accident reported to the police? **Yes / No**

Were traffic citations issued? **Yes / No** If "YES", to whom? _____

Did you go to the hospital? **Yes / No** If "YES", when? _____

If "YES", how did you get there? **Ambulance / Police Car / Private Transportation**

Were you admitted? **Yes / No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None / X-rays / Pain Medication / Stitches / Muscle Relaxants / Bandaged / Cervical Collar / Physical Therapy / Instructed Regarding Concussion / Instructed Regarding Sprains & Strains / Instructed to Call an Orthopedist / Instructed to Call a Private Physician / Referred to This Office / Other:** _____

What other doctors have you seen as a result of this injury? _____

_____ _____

Patient Signature Date

Patient Name: _____ **Date:** _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Occupation_____

Employer_____

Emergency Contact and Phone Number:

_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Range of Motion: yes/no
   a. What body parts: _____
B. Visual Disturbance: yes/no ☐ blurring l/r ☐ floaters l/r ☐ vision loss l/r ☐ hypersensitivity l/r
   % of time: ___ % of time: ___ % of time: ___ % of time: ___

C. Dizziness: yes/no % of time: ____
D. Anxiety/Depression: yes/no % of time: ____
E. Difficulty Sleeping: yes/no

2. Past Health History:

A. Surgeries:

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

B. Previous Injury or Trauma: _____

Have you ever broken any bones? Which? _____

C. Allergies: _____

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Patient Name: _____ **Date:** _____

3. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

A. Deaths in immediate family:

Cause of parents' or siblings' death Age at death

_____

_____

4. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities: _____

D. Lifestyle:

Hobbies: _____

Level of Exercise: _____

Alcohol Use: _____

Tobacco Use: _____

Drug Use: _____

Diet: _____

5. Medications:

Medication Reason for taking

_____

_____

_____

_____

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Patient Name: _____ **Date:** _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Arcadia Spinal Health Center** for services performed.

Patient or Guardian Signature _____
Date_____

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Patient Name: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

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Patient Name: _____ **Date:** _____

INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures (please initial each procedure you are consenting to):

____ spinal manipulative therapy	____ palpation	____ vital signs
____ range of motion testing	____ orthopedic testing	____ basic neurological testing
____ static surface EMG	____ dynamic surface emg	____ hydromassage therapy
____ microcurrent stimulation	____ low level laser therapy	____ flexion/distraction

____ Other (please explain)

_____

_____

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

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Patient Name: _____ **Date:** _____

INFORMED CONSENT (continued)

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you choose to use any of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Gregg Friedman and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian
(if a minor)

Dated: _____

Gregg Friedman, D.C.
Doctor's Name

_____
Signature

4203 E. Indian School Rd., Suite 210 Phoenix, AZ 85018 phone (480) 947-8381 fax (509) 352-2127

Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 1 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one) If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

4203 E. Indian School Rd., Suite 210 Phoenix, AZ 85018 phone (480) 947-8381 fax (509) 352-2127

Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 2 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one) If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

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Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 3 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one) If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

4203 E. Indian School Rd., Suite 210 Phoenix, AZ 85018 phone (480) 947-8381 fax (509) 352-2127

Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 4 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one) If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

4203 E. Indian School Rd., Suite 210 Phoenix, AZ 85018 phone (480) 947-8381 fax (509) 352-2127

Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 5 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one) If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

4203 E. Indian School Rd., Suite 210 Phoenix, AZ 85018 phone (480) 947-8381 fax (509) 352-2127

Patient Name: _____ **Date:** _____

NEW PATIENT HISTORY FORM

Symptom 6 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No (circle one) If yes, what was the intensity (1-10 w/10 the worst) ____ and frequency (%) ____ prior to the collision?
- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - No difference Morning Afternoon Evening Night Other _____
- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic
    - Other _____

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