110 S Mesa Dr Suite #4
Mesa, AZ 85210

Phone: 480-833-8863
Fax: 480-464-5516

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**

Provider Initials: _____

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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

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)

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: _____

Symptoms noted after crash/accident now resolved: _____

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_____

Provider Initials: _____

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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

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

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: _____ Provider Initials: _____

DOCTOR'S LIEN

TO: _____
_____
_____

Opie Chiropractic
Douglas D. Opie D.C.
110 S. Mesa Dr. #4
Mesa, AZ 85210

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his 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.

Dated: _____ Patient's Signature: _____

The undersigned does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency or the above-named doctor/doctor's office.

Dated: _____ Signature: _____

Please date, sign and return one copy
Reply envelope attached
Keep one copy for your records

Doctor's Lien

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPAA and Consent

For Use of Health Information

Name _____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated this_____ day of _____, 20 ___

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____
Signature of Parent/Guardian (Circle one)

BACK INDEX

Patient Name_____ Date_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

PAIN INTENSITY

0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain comes and goes and is moderate
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

SLEEPING

0 I get no pain in bed.
1 My sleep is slightly disturbed (less than 1 hour sleepless)
2 My sleep is mildly disturbed (1-2 hour sleepless)
3 My sleep is moderately disturbed (2-3 hour sleepless)
4 My sleep is greatly disturbed (3-5 hour sleepless)
5 My sleep is completely disturbed (5-7 hour sleepless)

SITTING

0 I can sit in any chair as long as I like
1 I can only sit in my favorite chair as long as I like
2 Pain prevents me from sitting more than 1 hour
3 Pain prevents me from sitting more than 30 minutes
4 Pain prevents me from sitting more than 10 minutes
5 I avoid sitting because it increases pain immediately

STANDING

0 I can stand as long as I want without pain.
1 I have some pain while standing but it does not increase with time
2 I cannot stand longer than 1 hour without increasing pain
3 I cannot stand longer than 30 minutes without increasing pain
4 I cannot stand longer than 10 minutes without increasing pain
5 I avoid standing because it increases pain immediately

WALKING

0 I have no pain while walking
1 I have some pain while walking but it doesn't increase with distance.
2 I cannot walk more than 1 mile without increasing pain
3 I cannot walk more than 1/2 mile without increasing pain
4 I cannot walk more than 1/4 mile without increasing pain
5 I cannot walk at all without increasing pain

PERSONAL CARE

0 I do not have to change my way of washing or dressing in order to avoid pain
1 My normal way of washing or dressing causes slight pain.
2 My normal way of washing and dressing causes mild pain
3 Washing and Dressing increases the pain and I change my way of doing it.
4 Because of pain I am unable to do some washing and dressing without help
5 Because of pain I am unable to do any washing and dressing without help

LIFTING

0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it causes extra pain
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed
3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned
4 I can only lift very light weights
5 I cannot lift or carry anything at all

TRAVELING

0 I can drive my car without any back pain
1 I can drive my car as long as I want with slight back pain
2 I can drive my car as long as I want with moderate back pain
3 I cannot drive my car as long as I want because of moderate back pain
4 I can hardly drive at all because of severe back pain
5 I cannot drive my car at all because of back pain.

SOCIAL LIFE

0 My social life is normal and gives me no extra pain
1 My social life is normal but increases the degree of pain
2 Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing etc.)
3 Pain has restricted my social life and I do not go out very often
4 Pain has restricted my social life to my home
5 I have hardly any social life because of pain

CHANGING DEGREE OF PAIN

0 My pain is rapidly getting better
1 My pain fluctuates but overall is definitely getting better
2 My pain seems to be getting better but improvement is slow
3 My pain is neither getting better or worse
4 My pain is gradually worsening
5 My pain is rapidly worsening

Index Score= [Sum of all statements selected/ (# of sections with a statement selected x 5)]

Back Index Score

NECK INDEX

Patient Name_____ Date_____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

PAIN INTENSITY
0 I have no pain at the moment
1 The pain is very mild at the moment
2 The pain comes and goes and is moderate
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

SLEEPING
0 I have no trouble sleeping
1 My sleep is slightly disturbed (less than 1 hour sleepless)
2 My sleep is mildly disturbed (1-2 hour sleepless)
3 My sleep is moderately disturbed (2-3 hour sleepless)
4 My sleep is greatly disturbed (3-5 hour sleepless)
5 My sleep is completely disturbed (5-7 hour sleepless)

READING
0 I can read as much as I want with no neck pain
1 I can read as much as I want with slight neck pain
2 I can read as much as I want with moderate neck pain
3 I can't read as much as I want because of moderate neck pain
4 I can hardly read at all because of severe neck pain
5 I cannot read at all because of neck pain

CONCENTRATION
0 I can concentrate fully when I want with no difficulty
1 I can concentrate fully when I want with slight difficulty
2 I have a fair degree of difficulty concentrating when I want
3 I have a lot of difficulty concentrating when I want
4 I have a great deal of difficulty concentrating when I want
5 I cannot concentrate at all

WORK
0 I can do as much work as I want
1 I can only do my usual work but no more
2 I can only do most of my usual work but no more
3 I cannot do my usual work
4 I can hardly do any work at all
5 I cannot do any work at all.

PERSONAL CARE
0 I can look after myself normally without causing extra pain
1 I can look after myself normally but it causes extra pain
2 It is painful to look after myself and I am slow and careful
3 I need some help but I manage most of my personal care
4 I need help every day in most aspects of self care
5 I do not get dressed, I wash with difficulty and stay in bed

LIFTING
0 I can lift heavy weights without extra pain
1 I can lift heavy weights but it causes extra pain
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed
3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently placed
4 I can only lift very light weights
5 I cannot lift or carry anything at all

DRIVING
0 I can drive my car without any neck pain
1 I can drive my car as long as I want with slight neck pain
2 I can drive my car as long as I want with moderate pain
3 I cannot drive my car as long as I want because of moderate pain
4 I can hardly drive at all because of severe neck pain
5 I cannot drive my car at all because of neck pain.

RECREATION
0 I am able to engage in all my recreation activities without neck pain.
1 The pain is very mild at the moment
2 The pain comes and goes and is moderate
3 The pain is fairly severe at the moment
4 The pain is very severe at the moment
5 The pain is the worst imaginable at the moment

HEADACHES
0 I have no headaches at all
1 I have slight headaches which come infrequently
2 I have moderate headaches which come infrequently
3 I have moderate headaches which come frequently
4 I have severe headaches which come frequently
5 I have headaches almost all the time.

Index Score= [Sum of all statements selected/ (# of sections with a statement selected x 5)]

Neck Index Score