AZMulticare Ltd. 20201 N. Scottsdale Healthcare suite 200, Scottsdale, AZ, 85255 phone 480-991-5555 fax 480-948-8295

Patient Registration and History Questionnaire

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 (_______) _________________________________

Employer: _____________________________________ Spouse's Name: _______________________________________

Occupation: ___________________________________ Spouse's Employer: ____________________________________

In case of emergency, notify______________________ Relationship: ____________ Phone (_______) ___________

Chief Complaint or Reason for Office Visit: ____

Specific Date and Time of Onset of Symptoms: ____

What makes your symptoms better? ____________________What makes your symptoms worse? __________________

What is the quality of your symptoms? (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**

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**

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

Patient's Name: ____ Date: ____________________

Date of Accident: ______________________________ Hour: ____________AM _________PM _______________

Specific Location of Accident: ____

Describe in detail, in your own words, how the accident happened: ____________________________________

____

____

In the accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? ___________________________

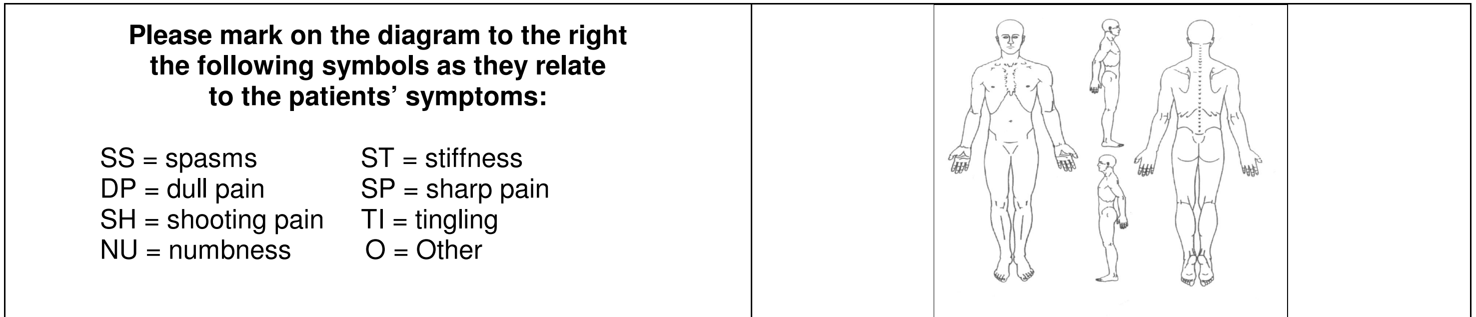
Did your car strike the other vehicle? ☐Yes ☐No **Did the other car strike your car? ☐Yes ☐No**

Were you struck from: ☐ Behind ☐ Front ☐ Side Impact ☐ Driver's Side ☐ Passenger's Side

Were traffic citations issued to: ☐ You ☐ the Driver of Your Car ☐ the Driver of the Other Car ☐ No Citations Given

Was your car heading: ☐ North ☐ South ☐ East ☐ West on ______________________________ (Street/Highway)

Was the other heading: ☐ North ☐ South ☐ East ☐ West on ______________________________ (Street/Highway)



Please mark on the diagram to the right the following symbols as they relate to the patients' symptoms:

SS = spasms	ST = stiffness
DP = dull pain	SP = sharp pain
SH = shooting pain	TI = tingling
NU = numbness	O = Other

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE 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
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ Depression	☐ Blurred Vision	☐ Tingling in Arms	☐ Loss of Taste
☐ Anxiety	☐ Sensitivity to Light	☐ Jaw Pain	☐ Any Burns
☐ Fainting	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ Any Stitches
☐ Muscle Spasms	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ Any Cuts

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: ___________________ to ____________________

Employer: ________________________________ Employers Telephone: _______________________________

Did you go to the hospital? ☐ Yes ☐ No: If Yes, Name of Hospital or E.R: ______________________________

Address: ____ Date of Hospitalization: ___________________

Attending E.R. Doctor: ______________________________ Treatment Given? __________________________

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

Patient's Name: ____ Date: __________________

PLEASE CHECK (✓) AS MANY OF THE FOLLOWING STATEMENTS THAT APPLY TO YOUR CASE.

☐ I have medical payment (Med-Pay) benefits, either, personally or through the driver of my vehicle.
☐ I have group health insurance benefits either directly or through my spouse or parents.
☐ **I have retained an attorney.**
☐ **I have not retained an attorney.**
☐ I have the adverse or third party information available. (Insurance company of the other driver.)

PLEASE PROVIDE THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: ____

Address: ________________________________Telephone:(_____) _____________Insured: ________________

Claim #: ________________________________Policy #: _________________________________

Telephone: (______) ________________________ Fax: (_______) _________________________

2) YOUR GROUP HEALTH INSURANCE COMPANY: ____

Address: ________________________________Telephone: (_____) ______________Insured: _______________

Date of Birth: ___________________________Policy #: ________________________ SS#: _________________

Telephone: (______) ________________________ Fax: (_______) _________________________

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: ______________________________

Address: _______________________________Telephone: (_____) _______________Claims Rep: _____________

Claim #: ________________________________Policy #: ______________________Insured: ________________

Telephone: (______) ________________________ Fax: (_______) _________________________

4) Attorney: _____________________________________Legal Assistant: ______________________________

Address: ____

Telephone: (______) ________________________ Fax: (_______) _________________________

HIPAA Compliance

______ Chiropractic _______ are 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: _______________