Desert Springs Chiropractic Center
904 N. McQueen Rd, Suite #103
Gilbert, Arizona 85233
Office (480) 668-1199
Fax (480) 668-7300

Personal Injury Insurance Information

Today's Date: _____ Accident Date: _____

Name: _____ ◯ Driver ◯ Passenger

Please provide as much information as possible so that your case can be set up to your financial advantage. In the state of Arizona Insurance laws read that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage, overpayment may occur. We only need to be paid once. so all overpayments will be reimbursed to you at the time you are released from care.

Primary Insurance: (Health Insurance that covers you)

Insured Name: _____

Insurance Name: _____

ID#: _____ Group _____

Insurance Phone # _____

Medical Payment Coverage: (One your automobile insurance, or the automobile insurance for the car in which you were a passenger, there may be coverage called "Medpay". This coverage is for any injuries that may have occurred to someone in the automobile. It will cover anything from an automobile accident that either was or wasn't your fault, to slamming your finger in your car door. **Using this portion of the policy cannot raise your premium or effect your records in any way**. In fact, this is exactly why you pay for "Medpay" on your insurance policy).

Claimant: _____

Policy Holder's Name: _____

Insurance Name: _____ Phone #: _____

Policy #: _____ Claim #: _____

Adjuster's Name: _____ Phone #: _____

Policy Verification by CA: _____

_____

Third Party Liability: This is the insurance information for the person who was in the "other car". The information can be found on the Accident Report.

Driver's Name: _____

Policy Holder's Name _____

Insurance Name: _____ Insurance Phone: _____

Policy #: _____ Claim #: _____

Adjuster's Name: _____ Phone#: _____

Policy Verification by CA: _____

_____

Attorney Information:

Name: _____ Phone#: _____

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Name: _____

Auto Injury Questions:

Were you the (select one)	○ Driver	○ Passenger	○ Pedestrian	
Were you struck from (select one)	○ Behind	○ Front	○ Left Side	○ Right Side ○ Parked
Did your car strike others involved?		○ Yes	○ No	
Did the other car strick yours?		○ Yes	○ No	
Did you have a seat belt on?		○ Yes	○ No	
Did any part of your body strike the car?		○ Yes	○ No	Which? _____
Were traffic citations issued to you?		○ Yes	○ No	
Issued to other drivers?		○ Yes	○ No	
To the driver of the car you were in?		○ Yes	○ No	

Work Injury Questions:

Was your employer notified?	○ Yes	○ No
Did the employer refer you anywhere?	○ Yes	○ No

Please describe how you felt after the accident (in as much detail as possible).

_____

_____

_____

DESERT SPRINGS CHIROPRACTIC NEW PATIENT INTAKE

Name:_____ Today's Date:_____

Address: _____ City: _____ State: _____ Zip:_____

Home Telephone: _____ Work: _____Cell:_____

Email Address: _____ Sex: ◯M ◯F

Social Security Number: _____ Birth Date: _____ Age:_____

Occupation: _____

Employer Name and Address:_____

Status: Spouse's Name: _____

Insurance: Primary_____ Secondary_____ Do you have one of the following? HSA Flex Amt $_____

Have you seen a Chiropractor before? ◯Yes ◯No If yes, when?_____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problems.

- ☐ Headaches
- ☐ Pins and Needles in arms
- ☐ Dizziness
- ☐ Numbness in fingers
- ☐ Fatigue
- ☐ Sleeping problems
- ☐ Cold Sweats
- ☐ Mood Swings
- ☐ Pins and Needles in legs
- ☐ Loss of smell
- ☐ Buzzing in ears
- ☐ Numbness in toes
- ☐ Depression
- ☐ Neck Stiff
- ☐ Constipation
- ☐ Lights bother eyes
- ☐ Menstrual Pain
- ☐ Fainting
- ☐ Back Pain
- ☐ Ringing in ears
- ☐ Loss of taste
- ☐ Irritability
- ☐ Cold hands
- ☐ Fever
- ☐ Problem urinating
- ☐ Menstrual irregularity
- ☐ Neck Pain
- ☐ Loss of Balance
- ☐ Nervousness
- ☐ Stomach upset
- ☐ Tension
- ☐ Cold feet
- ☐ Hot flashes
- ☐ Heartburn
- ☐ Ulcer

Main Complaint:_____

List any medications you are taking: _____

Have you been in a car accident recently? ◯Yes ◯No If so, when? _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Office Use only CT#: _____

Functional Rating Index

Regarding your MAIN COMPLAINT

In order to properly assess your condition, we must understand how much your main complaint problems have affected your ability to manage everyday activities.

For each item below, please select the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on shorts trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25 % of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name_____

PRINTED

_____ _____

Signature **Date**

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ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Lift Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Pet Care	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sit to standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Getting Dressed	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Shaving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Prolonged Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Prolonged Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Washing/Bathing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sweeping/Vacuuming	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Dishes	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Laundry	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Garbage	○ No Effect	○ Painful (can do)	○ Painful (limits	○ Unable to Perform
Driving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
_____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
_____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

Patient signature: _____

Printed Name: _____

Today's Date: _____

Desert Springs Chiropractic Center

Patient Name: _____ **Date:**

Symptom Intake Form

Symptom 1_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 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:
- 0 10 20 30 40 50 60 70 80 90 100
- When did the symptom begin? _____
  - Did the symptom begin ***suddenly*** or ***gradually***? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - 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, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

    _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, 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)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 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:
- 0 10 20 30 40 50 60 70 80 90 100
- When did the symptom begin? _____
  - Did the symptom begin ***suddenly*** or ***gradually***? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - 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, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

    _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, 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)
  - Morning Afternoon Evening Night Unaffected by time of day

Desert Springs Chiropractic Center

Patient Name: _____ **Date:**

Symptom 3 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 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:
- 0 10 20 30 40 50 60 70 80 90 100
- When did the symptom begin? _____
  - Did the symptom begin ***suddenly*** or ***gradually***? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - 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, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

    _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, 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)
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 4 _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 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:
- 0 10 20 30 40 50 60 70 80 90 100
- When did the symptom begin? _____
  - Did the symptom begin ***suddenly*** or ***gradually***? (circle one)
  - How did the symptom begin? _____
- What makes the symptom worse? (circle all that apply):
  - 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, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe):

    _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, 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)
  - Morning Afternoon Evening Night Unaffected by time of day