GRANT CHIROPRACTIC & PHYSICAL THERAPY

PERSONAL INJURY ACCIDENT INFORMATION

Patient Name: _____

1. **Date of Accident**: _____ **Time:** _____**AM or PM**
2. Were you: Driver _____ Passenger _____ Front Seat: _____ Back Seat:_____
3. Number of people in your vehicle_____ Other vehicle: _____
4. What direction were you going? North_____South_____East_____West_____
   Name of Street:_____ City _____
5. What direction was the other vehicle going? North_____South_____East_____West_____
6. Were you struck from: Behind_____Front_____Left side_____Right side_____
7. Were you knocked unconscious? Yes_____No_____ If YES, how long _____
8. Were the police notified? Yes_____No_____
9. Was anyone ticketed? Yes_____No_____ If YES, was it you ? _____
10. **In your words, please describe the accident**: _____
    _____
    _____
11. **Please describe how you felt**:_____
    A. During the accident: _____
    B. Immediately after the accident: _____
    C. Later that day: _____
    D. The next day: _____
12. **What are your present complaints and symptoms?** _____
    _____
13. **Where were you taken after the accident**?_____
14. **Have you been treated by another Doctor since the accident**? Yes_____No_____
    If YES, please list the Doctor's name and address:_____
    _____
    What type of treatment did you receive? _____
    _____
15. **As a result of this accident, have you lost time from work?** Yes _____No_____
    If YES, please complete the following:Date last worked:_____
    Type of work to you perform: _____
16. **Do you notice any activity restrictions as a result of this injury?** Yes_____No_____
    If yes, please explain/ list restrictions_____
    _____
    _____

GRANT CHIROPRACTIC & PHYSICAL THERAPY

PERSONAL INJURY INSURANCE INFORMATION

Name:_____ **Date**:_____

Date of Accident:_____ **Driver**: Yes or No **Passenger**: Yes or No

Please provide as much information as possible so 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. If there is more than one insurance coverage, overpayment can occur. We only need to be paid once, so all overpayments will be reimbursed to you after the case is settled.

Primary Insurance: (Your health insurance) We will need a copy of your health insurance card.

Insurance Co:: _____ Telephone Number: _____

ID or Policy #: _____ Group Number: _____

Medical Payment Coverage: On your automobile insurance, or the automobile insurance for the car in which you were a passenger, there maybe coverage called "Med-Pay". 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 the car door. Using this portion of the policy cannot raise your premium or affect your record in any way. In fact, this is exactly why you pay for "Med-Pay" in your insurance policy.

Claimant: _____ Policy Holder's Name: _____

Insurance Company: _____ Telephone #: _____

Policy #: _____ Claim #: _____

Adjuster's Name: _____ Telephone #:_____

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.

Accident Report Number: _____

Was anyone ticketed? Yes or No Who: _____

Driver's Name: _____ Policy Holder's Name: _____

Insurance Co. Name: _____ Telephone #: _____

Policy Number: _____ Claim Number: _____

Attorney Information: **Attorney's name:** _____

Firm Name: _____ Paralegal: _____

Telephone #: _____ Fax #: _____

Email Address: _____

GRANT CHIROPRACTIC
Life Center, P.C.

PATIENT APPLICATION FOR TREATMENT

Today's Date: _____ How were you referred to the clinic? _____

Name: _____ How would you like to be addressed? _____

Your Address: _____ City: _____

State: _____ Zip: _____ SS #: _____ Home #: _____

Your Occupation: _____ Wk #: _____

Emergency Contact: _____ Ph #: _____ Cell #: _____

Date of Birth: _____ Age: _____ Gender: _____

Marital Status S M W D Height: _____ Weight: _____ lbs

How many children do you have? _____ What are their ages? _____

The purpose or reason for this Appointment? _____

How often do you drink alcoholic beverages? _____

Do you smoke? ❑ Yes ❑ No How much? _____

Do you exercise? ❑ Yes ❑ No How often? _____ Type? _____

Do you have any allergies? (Specify): _____

Have you ever suffered from or been diagnosed as having: (circle yes or no for each)

Y N *Broken or Fractured Bones	Y N *Osteoarthritis	Y N Eating Disorder
Y N Circulatory Problems	Y N Epilepsy	Y N Alcoholism
Y N *Rheumatoid Arthritis	Y N Pacemaker	Y N Drug Addiction
Y N Seizures/Convulsions	Y N Strokes	Y N HIV Positive
Y N A Congenital Disease	Y N *Cancer	Y N Gall Bladder
Y N Excessive Bleeding	Y N Ulcers	Y N *Head Problems
Y N High/Low Blood Pressure	Y N Ruptures	Y N Depression
Y N *Diabetes	Y N Coughing Blood	Y N Tumors

* Explanation: _____

_____

_____

_____

When was your last physical exam? _____

When was the last time you were involved in an accident of any kind? _____

MEDICATION LIST

NAMES OF MEDICATION	NAMES OF VITAMINS	NON-Rx STRENGTH	Rx STRENGTH	DATE STARTED	DATE STOPPED	WHO PRESCRIBED DR. / SELF	
						D	S
						D	S
						D	S
						D	S
						D	S

FOR DOCTOR'S USE ONLY

❑ General

Injury Type:

❑ NDRA

Drug Allergies:

❑ See Meds Addendum

DATE: _____

ACCT: _____

PATIENT: _____

GRANT CHIROPRACTIC
Life Center, P.C.

SYSTEMS REVIEW

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), don't leave any blanks.

High Blood Pressure ____
Dizziness/Fainting ____
Insomnia ____
Low Resistance ____
Tension ____
Confusion ____
Fatigue ____
Ulcers ____
Eye/Vision Problems ____
Ear/Hearing Problems ____
Difficulty Breathing ____
Heart Problems ____
Loss of Bladder Control ____
Constipation ____
Diarrhea ____
Digestion Problems ____
Nausea ____
Female Problems ____
Prostate Problems ____
Diabetes ____
Hands/Feet Cold ____
Hand Tremors ____
Loss of Memory ____
Nervousness ____
Sweaty Palms ____
Speech Difficulty ____
Anxiety ____
Depression ____
Irritablility ____

FOR DOCTORS'S USE ONLY

DR. REVIEWED	SYSTEMS	SYMPTOMS
_____	General	Weight changes, fatigue, anorexia, weakness, fever, chills changes in activity
_____	Skin	Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes
_____	Head	Trauma, headaches, dizziness, light headed
_____	Eyes	Change in acuity of vision, use of corrective lensed, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge
_____	Nose	Rhinorrhea, epistaxis, allergies, airway obstruction
_____	Mouth & Throat	Ulcers, tooth pain/extractions, temporomandibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat
_____	Neck	Stiffness, lumps/swelling/masses, pain
_____	Lungs	Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats
_____	Cardiac	Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope
_____	Vascular	Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever
_____	Breasts	Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling
_____	Gastrointestinal	Unusal diet, sysphagia, regurgitation, dyspepsia, nausia, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, sonstipation, change in bowel habits, jaundice, abdominal swelling
_____	Genitournary	Polyuria, nocturia, oliguria, dysuria, uregency, incontinence, urine color changes, hematurea, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia
_____	Endocrine	Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstration, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric
_____	Hematopoietic	Anemia, abdominal bleeding, lymph node elargement/pain
_____	Musculoskelatal	Bone/Joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy
_____	Neurological	Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia
_____	Psychological	Mood swings, depression, anxiety, phobias

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

PROBLEM LIST

DR NAME/ FACILITY	PROBLEM	TYPE OF TREATMENT RECIEVED	FROM WHEN TO WHEN

FOR DOCTORS USE ONLY

❑ Reviewed External H P
❑ Release Records H P
❑ Request Records H P

EXTERNAL DX'D: _____

_____

DISABILITIES:

IMPAIRMENTS:

DATE: _____
ACCT: _____
PATIENT: _____

GRANT CHIROPRACTIC
Life Center, P.C.

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At it's worst)

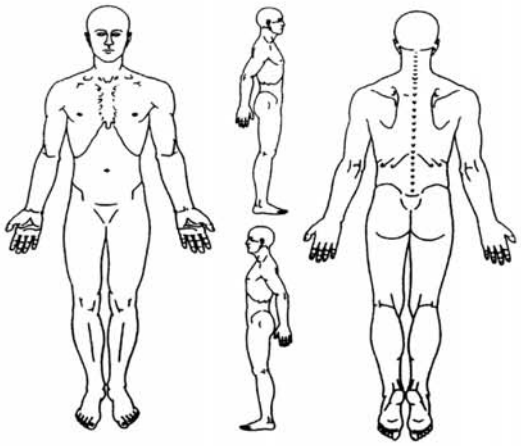
None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

		Occasional		*Intermittent*			*Frequent*			*Constant*	
0	10	20	30	40	50	60	70	80	90	100	%

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T**: tingling



6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? ❑ Yes ❑ No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates?_____ to _____
12. Are you Pregnant? ❑ Yes ❑ No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care	____
lifting	____
reading	____
concentrating	____
work	____
driving	____
sleeping	____
recreation	____
walking	____
sitting	____
standing	____
social life	____

Signature:_____

Date: ____/____/____

GRANT CHIROPRACTIC
& PHYSICAL THERAPY

CONSENT FOR TREATMENT

I, _____, authorize the performance upon myself of the following procedures: Chiropractic manipulation, hot/cold packs, electrical muscle stimulation, exercise therapy, stretching, spinal traction, massage, infrared, nutritional advice and prescription to be performed by or under Daniel Grant, D.C.'s supervision, or his designated employees, as clinically indicated.

I consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions that Dr. Grant may consider necessary or advisable in the course of my health care.

Dr. Grant and/ or his associates and assistants have explained the nature and purpose of the procedures, possible alternatives, the risks involved, the possible alternatives, the risks involved, the possible consequence, and the possibility of complications to me.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting report of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, please inform Dr. Grant or his staff and other accommodations will be made for you.

I acknowledge that no guarantee or assurance of the results that may be obtained from the procedure has been given by Dr. Grant, his associates and assistants.

Patient Signature: _____ Date: ____/_____/_____

Witness: _____ Relationship: _____

2510 W. Chandler Blvd., Suite #3
Chandler, AZ 85224

GRANT CHIROPRACTIC
& PHYSICAL THERAPY

PRIVACY PRACTICES ACKNOWLEDGEMENT

Date _____

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthday _____

Signature _____

If you are a minor, or if you are being represented by another party:

_____ _____
Personal Rep (Print) Personal Rep (Signature)

_____
Description of the authority to act on behalf of the patient

The patient named below has chosen not to sign the Privacy Practices Acknowledgement. This does not affect the type of treatment or quality of care the patient will receive in our office. We have attempted, to the best of our ability, to provide this patient with a copy of our Notice of Privacy Practices.

_____ _____
Name of Patient (Print) Date

_____ _____
Office Employee Title