

Smith Chiropractic • Dr. Eric C. Smith, D.C.

6431 Fairmount Ave. Suite 7

El Cerrito, CA 94530

Phone (510) 528-0378 • Fax (510) 528-0162

New Patient Registration and Accident Questionnaire ①

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**

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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

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:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Middle Back Pain | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Ears Ring |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Lower Back Stiffness | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Bruised Chest | <input type="checkbox"/> Radiating Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sleep Disruption | <input type="checkbox"/> Bruising Anywhere | <input type="checkbox"/> Tingling in Legs | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Tingling in Arms | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Jaw Pain (TMJ) | <input type="checkbox"/> Any Burns |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Upper Arm Pain | <input type="checkbox"/> Upper Leg Pain | <input type="checkbox"/> Any Stitches |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Lower Arm Pain | <input type="checkbox"/> Lower Leg Pain | <input type="checkbox"/> Any Cuts |

Other Symptoms: _____

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?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Medication (name) _____ | <input type="checkbox"/> Rest |
| <input type="checkbox"/> Heat (any kind) | <input type="checkbox"/> Exercise | <input type="checkbox"/> Other _____ |

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Patient's Name: _____ Date: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis <input type="checkbox"/> Yes	Lung Disease <input type="checkbox"/> Yes	Gout <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> Yes
Kidney Disease <input type="checkbox"/> Yes	Stomach/Ulcer <input type="checkbox"/> Yes	Heart Disease <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> Yes
Sciatica <input type="checkbox"/> Yes	Blood Pressure <input type="checkbox"/> Yes	Transfusion <input type="checkbox"/> Yes	Polio / MS <input type="checkbox"/> Yes
Colon Disease <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> Yes	Bleeding <input type="checkbox"/> Yes
Paralysis <input type="checkbox"/> Yes	Seizures <input type="checkbox"/> Yes	Arthritis <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> Yes
Anemia <input type="checkbox"/> Yes	Thyroid Disease <input type="checkbox"/> Yes	Drug Dependence <input type="checkbox"/> Yes	AIDS <input type="checkbox"/> Yes

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: _____