

GOODMAN CHIROPRACTIC CENTERS

Kenny Goodman, DC J Garett Goodman, DC
PO Box 1206 Thatcher, Az 85552

PATIENT REGISTRATION AND MVA HISTORY QUESTIONNAIRE

Date: _____

Name: _____ Age: _____ Date of Birth _____
LAST FIRST MIDDLE

Mailing Address: _____ Social Security # _____

City, State, Zip: _____ Male Female Marital Status: M S W D

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email Address: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify: _____ Relationship: _____ Phone (_____) _____

Date of Accident _____ Did you miss work due to the accident? Yes No

If yes, Dates missed: _____ What is your job description? _____

What makes your symptoms Better? _____ What makes your symptoms Worse? _____

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

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 and State

Do you have a history of any of the following diseases? :

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

Any other condition(s) not listed above that the doctor should be made aware of:

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
- Dizziness Radiating Pain Sleeping Problems Bruising Anywhere Tingling in legs
- Anxiety Loss of Smell Depression Blurred Vision Tingling in arms
- Jaw Pain Loss of taste Sensitivity to light Any Burns Upper arm pain
- Fainting Lower Arm Pain Upper leg pain Lower Leg Pain Muscle Spasms
- Any Cuts Any Stitches

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:

Your Auto Insurance Carrier _____ Insured: _____

Mailing Address: _____ Telephone: (____) _____

Claim # _____ Policy#: _____

YOUR GROUP HEALTH INSURANCE COMPANY: _____

Mailing Address: _____ Telephone: (____) _____

Policy#: _____ SS# _____

ADVERSE OR THIRD PARTY AUTO INSURANCE CARRIER? _____ Insured: _____

Mailing Address: _____ Telephone: (____) _____

Claim # _____ Policy#: _____ Claims Rep: _____

ATTORNEY _____ Legal Assistant: _____

Mailing Address: _____

Telephone: (____) _____ Fax: (____) _____

HAVE YOU NOTIFIED THE AUTO INSURANCE COMPANY THAT YOU ARE BEGINNING TREATMENT? Yes No

HIPAA Compliance:

Goodman Chiropractic Centers 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.

Financial Agreement:

If any signer is entitled to benefits under any insurance policy, the benefits are hereby assigned to Goodman Chiropractic for application on the patient’s bill; however, **IT IS UNDERSTOOD THAT THE UNDERSIGNED AND THE PATIENT ARE PRIMARILY LIABLE FOR PAYMENT OF THE PATIENT’S BILL (including any deductible).** It is intended by this provision to allow Goodman Chiropractic to bill and receive payments directly from the above insurance company without giving up our right to bill and collect from the undersigned all unpaid services rendered by Goodman Chiropractic. **Our office will not enter a dispute with your insurance company over any claims.** Please be advised that verification of insurance coverage is not a guarantee of benefit payments. **In the event your account is submitted to a collection agency, you will be responsible for all associated charges and fees. The undersigned will be responsible for a \$25.00 returned check fee.**

Signature below acknowledges that I understand and accept these policies. I have also read the Notice of our Privacy Practices. If requested, a copy will be provided to me.

Patient Signature: _____ **Date:** _____

Staff Initials: _____

INFORMED CONSENT

The nature of the chiropractic manipulation: The Doctor will use their hands, an instrument or both to move the joints of your body; this may result in an audible “pop” or “click”.

The material risks inherent in an adjustment: As with any healthcare procedure, there are certain complications that may arise during a chiropractic manipulation. This may include: strains, dislocations, fractures, disc injuries and stroke. This list is not all inclusive.

The probability of those risks: Fractures are rare and can result from an underlying weakness in the bones. The other complications listed are considered rare. One source states that stroke is a possible occurrence in 1/1,000,000 cases or higher, even so we employ tests during our examination to identify if you may be susceptible to that kind of injury.

Ancillary treatments recommended: Ice, Moist Heat Packs, Electrical Muscle / Interferential Stimulations, Stretching / Strengthening Exercises, Neuromuscular Re-education, and Mechanical / Decompression Traction.

Risks involved with the recommended ancillary treatments: Ice, Heat and Electrical Muscle Stimulations (EMS) can cause burning. The EMS can cause skin irritation underneath the active pads. Stretching / Strengthening Exercises and Mechanical Traction can cause temporary post treatment soreness or reflex muscle spasms. This list is not all inclusive.

Other treatment options for your condition can include: Medical care with prescription drugs, self-management with over-the-counter medication, rest, and / or surgery. There are material risks inherent in each of these options including but not limited to: addiction to medication, side effects of medication, improper self-dosages and surgical risks including complications from either the procedure or the anesthesia or both.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I have read or have had read to me the above explanation of the chiropractic adjustment and the related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and I have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to treatment.

Patient Printed Name _____ Date _____

Patient Signature: _____

..... For Office use only

Dr. Signature _____

The patient had the following questions and was supplied the following answers:

It is my clinical opinion this patient is oriented to time and space:	Yes	No
It is my clinical opinion this patient was able to understand the language involved:	Yes	No

MOTOR VEHICLE CRASH HISTORY

Was the accident on the job? Yes No

Were you the Driver Front Seat Passenger Rear Seat Passenger Motorcycle Operator
 Motorcycle Passenger Other Vehicle driven by: _____

Did your vehicle strike the other vehicle? Yes No Did the other vehicle strike your vehicle: Yes No

Were you struck from: Behind Front Driver's side Passenger's side Other _____

Were traffic citations issued to: You Driver of your car Driver of other car None

Was your vehicle heading: North South East West on _____ (Street)

Was the other vehicle heading: North South East West on _____ (Street)

Your estimated speed at the moment of the accident: Full Stop Slowing Accelerating Other _____

Your Vehicle (Year, Make, Model) _____

Other Vehicle (Year, Make, Model) _____

Time of day: Daylight Dawn Dusk Dark

Road conditions: Dry Damp Wet Snow Ice Other _____

Head rest position: None Integral type Adjustable: Up Down Don't know

If adjustable, was the position altered by the accident? Yes No

Was the seat back adjustment altered by the accident? Yes No

Did the air bag deploy? Yes No If Yes, were you struck? Yes No Were you burned? Yes No

Was your body position: Good Leaning forward Other _____

Was your head facing: Forward Left _____° Right _____° Up _____° Down _____°

What position were your hands: One on Wheel Two on wheel N/A

Were brakes applied at impact? Yes No Were you aware of the impending crash: Yes No

Accident Description: _____

During the crash:

Did you strike any body parts in the vehicle? Yes No If yes, describe _____

Did vehicle strike any objects after crash? Yes No If yes, describe _____

Were you wearing hat or glasses? Yes No If yes, still on after crash? Yes No

Did you lose consciousness? Yes No If yes, for how long _____

Were police on-scene? Yes No If yes, was a report made? Yes No

After the crash, did you have any of the following symptoms?

Headache Dizziness Nausea Confusion/disorientation Neck Pain Back Pain

Paresthesia Other _____

When did symptoms first appear? Immediately Same day Next day Other _____

Where did you go after the accident? Home Work Hospital – mode of transportation? _____

Emergency Room: Yes No Hospital Name: _____ X-rays: Yes No

X-Rays were taken of: _____ Results: _____

Lab work: Yes No Cervical Collar Yes No Ice RX _____ Other _____

Follow-up Instructions: _____ None

Treatment History:

Doctor: _____ Specialty: _____ First date seen: _____

Referred by: _____ Type of treatment: _____ Frequency of treatment: _____

Duration of treatment: _____ Currently being treated? Yes No

Additional Tests: _____ Did treatment help? Yes No

Notes: _____

For Doctor office use only

CURRENT CHIEF COMPLAINTS

Time in: _____ Time out: _____ Date of Exam: _____ Date of accident: _____
Doctor: _____ Doctor Signature: _____

1. _____
Onset _____ Provocative _____
Palliative _____ Quality _____
Radiation / Location _____

Severity (VAS): Now _____ Avg. _____ Min to Max Range _____ - _____ /10
Time: Better a.m. Worse Better p.m. Worse
Frequency: < 25% intermittent 26-50% occasional 51-75% frequent constant > 76%

2. _____
Onset _____ Provocative _____
Palliative _____ Quality _____
Radiation / Location _____

Severity (VAS): Now _____ Avg. _____ Min to Max Range _____ - _____ /10
Time: Better a.m. Worse Better p.m. Worse
Frequency: < 25% intermittent 26-50% occasional 51-75% frequent constant > 76%

3. _____
Onset _____ Provocative _____
Palliative _____ Quality _____
Radiation / Location _____

Severity (VAS): Now _____ Avg. _____ Min to Max Range _____ - _____ /10
Time: Better a.m. Worse Better p.m. Worse
Frequency: < 25% intermittent 26-50% occasional 51-75% frequent constant > 76%

4. _____
Onset _____ Provocative _____
Palliative _____ Quality _____
Radiation / Location _____

Severity (VAS): Now _____ Avg. _____ Min to Max Range _____ - _____ /10
Time: Better a.m. Worse Better p.m. Worse
Frequency: < 25% intermittent 26-50% occasional 51-75% frequent constant > 76%

PAST HISTORY

Previous injuries (MVA, WC, Sports) _____

Previous Treatment History / History of Current Complaints / Prior Treatment by DC

Date	Dr. / Hospital	Treatment	Response (+) (-) (NC)	Treatment Duration	Test (s)	Test Results

Past Hospitalizations / Illnesses / Fractures None _____
 Surgical History (Date and Residuals) None _____
 General State of Health _____ Allergies _____
 Medications / Vitamins _____

FAMILY HISTORY

1. Father 2. Mother 3. Sister (A,B,C,D) 4. Brother (A,B,C,D)

Cancer () _____ Diabetes () _____ Cardiac () _____ TB () _____
 CVA () _____ BP () _____ Epilepsy () _____ Other _____

Psycho – Social History

Date	Occupation	WC Claims	Disabilities	Enjoyed

Activities of Daily Living (Changes as a result of injury) _____

Recreational / Exercise: _____ Type: _____
 Frequency _____ / Week Duration _____ Min / Hour(s) _____

Social Habits: (Circle appropriate responses and fill in the blank)

Tobacco: _____ pk/____ day/week for _____ years Chew: _____ years Pipe: _____ years
 Caffeine (Soda, Coffee, Tea) _____ / day Alcohol _____ glasses of Wine, Beer, Mixed Drink / Day Wk. Mo.
 Sleep interrupted? X's / Night for Weeks Months Years

Work Routine

	Able	Restricted	Unable	
Sit in office chair	1	2	3	4 5
Stand Erect	1	2	3	4 5
Climb Steps / Stairs	1	2	3	4 5
Stoop to retrieve	1	2	3	4 5
Crouch to retrieve	1	2	3	4 5
Kneel to retrieve	1	2	3	4 5
Reach over head	1	2	3	4 5
Lift waist to shoulder height	1	2	3	4 5
Carry object, 100 feet	1	2	3	4 5
Push	1	2	3	4 5
Pull	1	2	3	4 5
Balance	1	2	3	4 5
Crawl	1	2	3	4 5
Reach	1	2	3	4 5
Handle objects appropriately	1	2	3	4 5
Finger / Hand Strength / Coordination	1	2	3	4 5