Moon Valley Chiropractic PI Intake Forms
Jamey Reichow, DC
15420 N. 7th Street, Suite B, Phoenix, AZ 85022 / Phone (602)298-0292 / Fax (602)298-6961

Name _____ Referred by _____

Age: _____ Date of Birth _____ Address _____

City: _____ State _____ Zip _____ Cell Phone _____

Home Phone _____ Work Phone _____

Marital Status: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widowed

Emergency Contact _____ Phone _____ Relationship _____

Date of accident _____ Hour _____ AM / PM Who was at fault: ME OTHER DRIVER WORK RELATED

Specific location of accident _____ Type of vehicle (car, motorcycle, etc.) _____

Describe in detail how the accident happened _____

_____

_____

In the accident, were you the ❑ Driver ❑ Passenger ❑ Pedestrian ❑ Other _____

Did your vehicle strike the other vehicle ❑ Yes ❑ No Did the other car strike your vehicle ❑ Yes ❑ No

Were you struck from ❑ Front ❑ Behind ❑ Driver's Side ❑ Passenger's Side Estimated speed _____

Were the police on the scene ❑ Yes ❑ No Was a report made ❑ Yes ❑ No Do you have a copy of the report ❑ Yes ❑ No

Were traffic citations issued ❑ Yes ❑ No Who received the citation ❑ Driver of your vehicle ❑ Driver of the other vehicle

Were you aware of the impending crash? ❑ Yes ❑ No Did you lose consciousness? ❑ Yes ❑ No

Following the crash did you feel any of the following: ❑ Headache ❑ Dizziness ❑ Nausea ❑ Neck Pain

❑ Confusion/disorientation ❑ Paresthesia ❑ Back Pain ❑ Other _____

When did symptoms start ❑ Immediately ❑ Same day ❑ Next day ❑ Other _____

Where did you go after the accident? ❑ Home ❑ Work ❑ Hospital Mode of transportation _____

Did you go to the ER ❑ Yes ❑ No If yes, which hospital _____

Attending ER Physician _____ Date of Hospitalization _____

Hospital Address _____

Did the hospital take X-Rays ❑ Yes ❑ No If yes, which body parts were X-Rayed _____

Results _____

Was lab work done ❑ Yes ❑ No If yes, what were the results _____

Were you given a cervical collar ❑ Yes ❑ No What were your follow up instructions _____

_____

_____

_____

Name _____ Date of Birth _____

List doctors you have seen and what treatment have you had since the accident

Doctor Name	Treatment	Frequency	Duration	Was this treatment helpful
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

Check ANY and ALL of 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
❑ Sleep 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

Changes in daily activity since accident _____

_____

Have you lost time from work ❑ Yes ❑ No If yes, what dates _____

Employer _____ Employer Phone _____

Work Routine	**Able**		**Restricted**	**Unable**	**Comments**
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 overhead	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 coordination	1	2	3	4	5

Name _____ Date of Birth _____

Do you have a history of any of the following?

❑ Tuberculosis	❑ Lung Disease	❑ Gout	❑ Diabetes
❑ Kidney Disease	❑ Stomach / Ulcer	❑ Heart Disease	❑ Hepatitis
❑ Sciatica	❑ Blood Pressure	❑ Transfusion	❑ Polio / MS
❑ Colon Disease	❑ Stroke	❑ Cancer	❑ Bleeding
❑ Paralysis	❑ Seizures	❑ Arthritis	❑ Asthma
❑ Anemia	❑ Thyroid Disease	❑ Drug Dependence	❑ AIDS

General Health Information

Please list any allergies _____

Do you smoke? ❑ Yes ❑ No If yes, how much per day _____

Do you drink? ❑ Yes ❑ No If yes, how much per day _____

Caffeine Use (coffee / tea / soda) ❑ Yes ❑ No

Is your sleep interrupted? How many times per night? _____ For how long? _____

Past Accident History

Please list previous accidents you have had. This would include Motor Vehicle, Sports, Etc.

Date _____ Type of accident _____ Injuries _____

Treatment _____

Date _____ Type of accident _____ Injuries _____

Treatment _____

Date _____ Type of accident _____ Injuries _____

Past Hospitalizations

Date _____ Reason _____

Date _____ Reason _____

Date _____ Reason _____

Date _____ Reason _____

Date _____ Reason _____

Past Fractures

Date _____ Bone(s) _____ ❑ Set/Cast ❑ Surgery ❑ Other _____

Date _____ Bone(s) _____ ❑ Set/Cast ❑ Surgery ❑ Other _____

Date _____ Bone(s) _____ ❑ Set/Cast ❑ Surgery ❑ Other _____

Date _____ Bone(s) _____ ❑ Set/Cast ❑ Surgery ❑ Other _____

Name _____ Date of Birth _____

Review of Symptoms

1 – Presently has symptom 2 – Has had symptom previously 3 – Related to accident (date_____)

General
___ Allergy
___ Chills
___ Convulsions
___ Dizziness
___ Fainting
___ Fatigue
___ Fever
___ Headache
___ Sleep loss
___ Weight loss
___ Nervousness / depression
___ Neuralgia
___ Numbness
___ Sweats
___ Tremors

Eyes, Ears, Nose, Throat
___ Asthma
___ Colds
___ Sore throat
___ Deafness
___ Dental decay
___ Earache / noises
___ Ear discharge
___ Sinus infection
___ Enlarged glands
___ Enlarged thyroid
___ Nose bleeds
___ Failing vision
___ Far sighted
___ Gum trouble
___ Hay fever
___ Hoarseness
___ Nasal obstruction
___ Near sighted

Musculoskeletal
___ Arthritis
___ Bursitis
___ Foot trouble
___ Hernia
___ Low back pain
___ Lumbago
___ Neck pain / stiffness
___ Shoulder blade pain
___ Pain or numbness in:
- ❑ shoulders
- ❑ Arms
- ❑ Elbows
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Feet

___ Painful tailbone
___ Poor posture
___ Sciatica
___ Spinal Curvature

Genito-Urinary
___ Bedwetting
___ Blood in urine
___ Frequent urination
___ Inability to control bladder
___ Kidney infection or stones
___ Painful urination
___ Prostate trouble
___ Pus in urine
___ Painful menstruation
___ Hot flashes
___ Irregular cycle
___ Lumps in breasts

Cardiovascular.
___ Hardening of arteries
___ High blood pressure
___ Low blood pressure
___ Pain over heart
___ Poor circulation
___ Rapid heart beat
___ Slow heart beat
___ Swelling of ankles

Respiratory.
___ Chest Pain
___ Chronic cough
___ Difficult Breathing
___ Spitting up blood
___ Wheezing

Gastrointestinal .
___ Belching or gas
___ Colitis
___ Colon trouble
___ Constipation
___ Diarrhea
___ Difficult digestion
___ Distention of abdomen
___ Excessive hunger
___ Gall bladder trouble
___ Hemorrhoids
___ Intestinal worms
___ Jaundice
___ Liver trouble
___ Nausea
___ Pain over stomach
___ Poor appetite
___ Vomiting
___ Vomiting blood

Other _____

_____

_____

_____

_____

Name _____ Date of Birth _____

Have you retained an attorney? Yes No

Law Firm _____

Attorney name _____ Phone number _____

Legal assistant name _____ Fax _____

Insurance Information

YOUR Auto Insurance carrier _____ Insured _____

Carrier address _____ Phone _____

Claim # _____ Policy # _____

Claims Representative Info _____

YOUR Medical Insurance carrier _____

Carrier address _____ Phone _____

Policy # _____ Date of birth _____ SS# _____

Policy holders name _____ Are you a dependent Yes No

OTHER driver's insurance carrier _____ Insured _____

Carrier address _____ Phone _____

Claim # _____ Policy # _____

Claims Representative Info _____

HIPPA Compliance

Moon Valley Chiropractic is required by law to maintain the HIPPA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that you have 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 _____

ASSIGNMENT OF BENEFITS IN PERSONAL INJURY CASES

I authorize Moon Valley Chiropractic Clinic to receive lien payment from all liable insurance companies, attorneys or myself for all monies due on my account. I understand that all coverage in effect at the time of my injury will be billed. Any over-payments will be promptly returned to me. In the event that there is no valid coverage or that I have exceeded my insurance limit, I will remain responsible for the charges incurred.

Further, I hereby authorize Moon Valley Chiropractic Clinic or any of their employees to sign my name on the back of ay draft or check which they receive for services rendered from my insurance company, whether pursuant to medical payments coverage or health insurance coverage, as long as I have an outstanding balance with them. Said amount shall be credited against my account and shall reduce my outstanding balance accordingly.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctor's specific recommendations. A complete list is available at the front desk.

There is no charge for **THE INITIAL CONSULTATION.** This does not include any X-rays or exams that are conducted. X-ray services are subject to separate outside fees. All fees are subject to change without notice.

Any financial arrangements are to be determined prior to services rendered. I agree to the terms above and acknowledge that in the event that there is an outstanding balance which fails to be cured within sixty (60) days, my account with Moon Valley Chiropractic Clinic will be turned over to collection. I understand that should this happen, I will remain responsible for any and all addition collection fees and/or attorney and court costs.

Date _____

Patient Signature _____

Guardian Signature if patient is a minor _____

RELEASE OF INFORMATION / RECORDS AUTHORIZATION

I _____ born _____ and
Print Name Birthdate

living at _____
Street Address City State Zip

authorize _____ at _____
Doctor Name Facility name and address

to release the following information and records from my medical file:

- ❑ History and Physical
- ❑ Consultation Report
- ❑ Progress Notes
- ❑ Rehab Progress Notes
- ❑ Other _____
- ❑ Discharge Summary
- ❑ Laboratory Reports
- ❑ X-Ray Reports

Please send this information to:

MOON VALLEY CHIROPRACTIC
15420 N. 7th Street, Suite B
Phoenix, AZ 85022 as soon as possible to provide continuum of care.

This authorization will be valid for the period of six (6) months and limited to the information I have requested above. I understand this information is confidential and may include information regarding drug / alcohol / HIV and/or AIDS related conditions. I understand that this information will not be further disclosed or used for any purpose other than as stated in the authorization. I understand that I have the right to inspect and copy any written information to be disclosed and the right to revoke this consent at any time per written notice. I understand the requested copies for personal use will be subject to a reasonable fee.

Patient Signature _____ Date _____

Responsible Party _____ Date _____

Witness _____ Date _____