RYKEN CHIROPRACTIC & WELLNESS CENTER

610 North Alma School Rd. Suite 50
Chandler, Arizona 85224

INITIAL DOCTOR-NEW PATIENT INTERVIEW FORM

Patient: ______________________________ Age: ________ Birth Date: ____________

Time In: __________ Time Out: __________ Date of Accident: ____________________

Doctor: ________________________ Date Of Exam: ____________________

Sex: ☐ M ☐ F Marital Status: __________ Spouse Name: ______________ # of Children: __________

Occupation: ______________________ Years: ______ Employer: ____________________

Are you or have you missed time from work? ☐Yes ☐ No Type of Work: ☐ Office ☐ Clerical ☐ Light ☐ Moderate ☐ Heavy Labor

Describe the type of work performed: ______________________________

Were you on-the-job when the accident occurred? ☐ Yes ☐ No

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Rear Seat Passenger ☐ Other ____________________

Vehicle was driven by: ______________________________

Did your vehicle strike another vehicle? ☐ Yes ☐ No Did another vehicle strike your vehicle? ☐ Yes ☐ No

Were you struck from: ☐ Behind ☐ Front ☐ Driver's side ☐ Passenger's side ☐ other ______________

Were traffic citations issued? To whom? ☐ You ☐ Driver of your vehicle ☐ Driver of other vehicle ☐ None

Were police at the scene? ☐ Yes ☐ No If yes, was a report made? ☐ Yes ☐ No Did accident occur on ☐ public or ☐ private property

Your vehicle was heading: ☐ North ☐ South ☐ East ☐ West on ______________________ (Street/highway)

The other car heading: ☐ North ☐ South ☐ East ☐ West on ______________________ (Street/highway)

Your Vehicle (Year, Make, Model): ______________________________

Your speed at the moment of accident: ☐ Full Stop ☐ Slowing ☐ Accelerating ☐ Legal Limit

The other Vehicle (Year, Make, Model) ______________________________

Time of day: ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark Road conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice ☐ Other __________

Head restraints: ☐ 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

Type of Restraints: ______________________________

Did air bag deploy? ☐ Yes ☐ No If Yes, were you struck by airbag? ☐ Yes ☐ No Were you burned? ☐ Yes ☐ No

Body position: ______________ Head position: ☐ Forward ☐ Left _____° ☐ Right _____° ☐ Up _____° ☐ Down _____°

Position of Hands: ☐ One on steering wheel ☐ Two on steering wheel ☐ N/A Were brakes applied at impact? ☐ Yes ☐ No

Dr. Initials: ________

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Patient: ____________________

Accident Description: (How did the accident happen?) ____________________

____

____

Were you aware of impending crash?: ☐ Yes ☐ No

Did your body hit any part of your vehicle? ☐ Yes ☐ No If yes, describe ____________________

Did anything inside the vehicle strike you? ☐ Yes ☐ No If yes, describe ____________________

Did your vehicle hit any other object after the crash? ☐ Yes ☐ No If yes, describe ____________________

Were you wearing a hat or eye or sunglasses? ☐Yes ☐ No If yes, were they still on after crash? ☐ Yes ☐ No

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

Estimated damage to your vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Estimated damage to other vehicle: ☐ None ☐ Minimal ☐ Moderate ☐ Major

Since the crash, tell me **ALL** symptoms or injuries you have experienced and specifically when each began: ____________________

____

____

Where did you go after accident? ☐ Hospital ☐ Urgent Care ☐ Family Provider ☐ Home ☐ Work ☐ Other__________

Emergency Room Treatment:

Were you seen in the ER: ☐ Yes ☐ No Which hospital: ____________________ Were taken by ambulance? ☐ Yes ☐ No

Date seen if not taken by ambulance __________

Was treatment given? ☐ Yes ☐ No If yes, X-rays: ☐ Yes ☐ If yes, which body parts x-rayed ____________________

Results of X-rays: ____________________ Lab work ☐ Yes ☐ No Results: ____________________

Cervical collar ☐Yes ☐No Ice ☐ Yes ☐ No Medication: ☐ Yes ☐ No If yes, name of Rx: ____________________

Other treatment: ____________________ Follow-up Instructions: ____________________ ☐ None

Work restriction ☐ Yes ☐ No If yes, describe____________________

Other Treatment Since Crash #1:

Doctor: ____________________ Specialty: ____________________ Date first seen: ____________________

Referred by: ____________________ Treatment type: ____________________ Treatment frequency: __________

Treatment duration: ____________________ Currently treating? ☐ Yes ☐ No

Work restriction ☐ Yes ☐ No If yes, describe____________________

Special tests: ____________________ Referred to: ____________________

Did treatment help? ☐ Yes ☐ No Comments: ____________________

Dr. Initials: __________

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Patient: ______________________________

Previous Injuries, Hospitalizations, Surgeries

Date	Doctor/Hospital/ Condition	Treatment	Response (+) (-) (NC)	Treatment Duration	Test(s)	Test Result

Medications/Vitamins: ______________________________

Allergies: ______________________________

Family History: #1.Father, #2.Mother, #3.Sister (A, B, Etc), #4.Brother (A, B, Etc.)

Cancer	Diabetes	Heart Disease	CVA
HBP	Epilepsy	TB	Other
Other	Other	Other	Other

Psycho-Social History:

Changes to Activities of Daily Living Since the Accident: ______________________________

____

Recreational/Exercise: Type: ______________ Freq. ____/Wk; Duration _____ Min. / Hrs: ______________

Social Habits (Please Circle Appropriate Responses and Fill In The Blanks)

Tobacco: _______ Pack / ___Day, Week, For ___ Yrs; Chew ______ Yrs; Pipe _____ Yrs Caffeine (Soda, Coffee, Tea) ______/ Day

Alcohol ______ Glasses Of Wine, Beer, Mixed Drink/ Day, Wk, Mo.; Sleep Interrupted? ____X's / Night For ____ Weeks Mo Yrs

Dr. initials: __________

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Chandler, Arizona 85224

Patient: ______________________________

Work Routine/Duties under Duress	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 strength/coordination	1	2	3	4	5	

REVIEW OF SYSTEMS: *Please write all numbers that apply: #1. Presently have, #2. Previously had, #3. Related to crash*

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
___Spitting up phlegm
___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: ______________________________

Dr. Signature: ______________________________ Date ______________

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290 S. Alma School Road
Chandler, Arizona 85224

Patient: ____________________

Work Routine/Duties under Duress	Able		Restricted	Unable		Comments
Sit in office chair	1	2	3	4	5	
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___Sweats
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___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose bleeds
___Failing vision
___Far sighted
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___Near sighted

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___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

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___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: ____________________

Dr. Signature: ____________________ Date ____________________

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290 South Alma School Rd. Suite 5-7
Chandler, Arizona 85224

Patient's Name: ______________________________ Date: ______________

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: ______________

290 S. Alma School Road
Chandler, Arizona 85224
Phone: (480) 857-1991
Fax: (480) 857-2036

PATIENT FINANCIAL AGREEMENT

(Equitable Lien/Benefit Assignment Contract and Indemnification Agreement)

Please read the following very carefully as it concerns your financial responsibility to the Health Care or Service Provider from whom you are about to receive services.

I, the undersigned Patient, hereby agree to establish a lien/assignment of benefits or claim in favor of **Ryken Chiropractic & Wellness Center** by this contract and pursuant to any state statutes that apply in the state where I reside. I give my permission for **Ryken Chiropractic & Wellness Center** and/or their agent to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from the accident which occurred on ___________(date) and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so, I have entered into a contract with the above names health care or service provider. **This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy**, settlement, compromise, judgment verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident, in such sums necessary to fully compensate the health care or service provider from whom I have received care. The lien/assignment created by the Equitable Lien Contract and Indemnification Agreement shall have priority from the time and date on which said documents are actually filed, or recorded or served on the liable parties, over any subsequent liens or assignments of my interests in claims arising from this accident.

In exchange for providing necessary medical care without requiring payment in full at the time service is received, I agree to be responsible for all charges associated with my care, regardless of the insurance companies' reimbursement, settlement or compromise. Charges for which I agree to be responsible include any administrative expenses associated with processing my claim such as charges incurred by the provider for recording and/or serving notice of this lien/assignment upon any liable parties and their insurance companies. Also included are any collection charges or legal costs and fees incurred by the provider while attempting to collect the medical bills related to this claim should such activity become necessary.

I further understand that as part of the process of recording a lien/assignment, I will receive, via certified mail, a copy of the lien/assignment enclosed and that this copy is for my own records and does not require any response on my part.

____ Date:________________

(Please Print Patient's Name)

____

(Patient's Signature. If patient is a minor, have guardian sign and indicate same)