PARADISE VILLAGE CHIROPRACTIC CENTER

CHIROPRACTIC • ACUPUNCTURE • REHABILITATION • FUNCTIONAL MEDICINE • SPORTS THERAPY
13835 N. Tatum Blvd. Ste. 3, Phoenix, AZ 85032 Phone: (602) 953-1900 Fax: (602) 953-1901

Confidential Patient Information

Please Print, there are two sides, please fill out the front and back

Name: ______________________________________

Address: ____________________________________

City: ______________ ST: ______ Zip: ____________

Phone: (______)______________________________

Cell Phone: (______)__________________________

Age: ________ Date of Birth: __________________

Email: ______________________________________

Occupation: ________________________________

Employer: __________________________________

Employer Address: ___________________________

____

Office Phone:(______)_________________________

Marital Status: (S) (M) (W) (D) Children: _______________

Name of Spouse: _________________________________ Occupation: ______________________________

Spouse's Employer: ________________________________ Phone: (______)__________________________

How were your referred to this office? ____

Purpose of this appointment? ____

Other doctors seen for this condition? ____

Did Accident/Injury occur at work? (NO) (YES) Date: ________________ Time: _________________

Was it reported? (NO) (YES) If so to whom? __________________________________

Were you involved in an Auto Accident? (NO) (YES) Date: ________________

Name of Primary Care Physician: ______________________________ Phone (_____)___________________

Have you been treated for any other health condition in the past year? (NO) (YES)

If yes, please describe: ____

When was your last physical exam? ________________________ Laboratory testing? _________________

OVER

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient Signature:____ Date:_________________________

Parent/Guardian Signature Authorizing Care: ____

Information taken by:____ Date:_________________________

CONSENT FOR TREATMENT

X____________ I acknowledge and understand that in presenting myself for treatment and continuing care at Paradise Village Chiropractic Center, that I authorize and consent to the administration and performance of tests and treatments which may be ordered by the physician or designated assistant and carried out by members of this office staff.

REGARDING INSURANCE

X____________We are in and out of network with various insurance companies. Please ask the receptionist if your insurance company is included. Participation is subject to change. Please be aware some, perhaps all, of the services provided may be non-covered services and this will be the patient's responsibility. All deductibles and co-pays are due at the time of service.

USUAL AND CUSTOMARY RATES

X____________Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless we have a participating agreement with the company.

PAYMENT AGREEMENT

I hereby assume full responsibility for and agree to pay all costs, charges and expenses incurred as the patient, to Paradise Village Chiropractic Center/Functional Health Systems S.C. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not contingent upon payment of any such costs, charges or expenses by any third party. An assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed a waiver of the provider's right to require payment directly, from the undersigned. The provider expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all cost of collection, including but not limited to reasonable attorney fees. If the undersigned is more than one person, every obligation hereunder shall be joint and several.

I understand that this office has a $25.00 administrative fee added to my bill each month my balance is outstanding. Outstanding balances include unpaid deductibles, co-payments or patient portions.

____ ____________________

Signature of Patient or Responsible Party **Date**

____ ____________________

Patient Name (Printed) **Date of Birth**

Auto Injury Questionnaire

Paradise Village Chiropractic Center
13835 N. Tatum Blvd. Ste 3
Phoenix, AZ 85032

Patient Name ____ ***Date*** ____

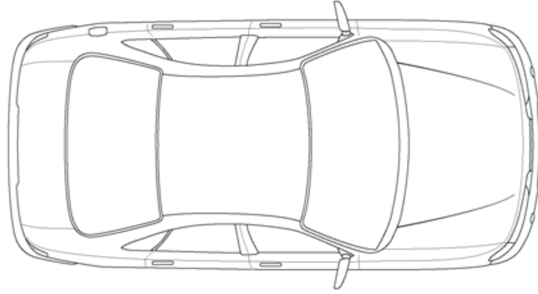
Date of Injury: ____________ ***Time of Injury:*** __________ (am / pm)

Car Make Model and Year:
Yours: Theirs:

Where did the acident occur: ______________________________

Were you the: ☐ Driver ☐ Front Seat Passenger ☐ Back Seat Passenger ☐ Other ______________

Where was the car impacted:



Were you wearing a seat belt?: ☐ Yes ☐ No

What was your body position?: ☐ Good / ☐ Forward / ☐ Leaning to side

What was your head position?: (mark all that apply) ☐ Neutral ☐ Left ☐ Up ☐ Forward ☐ Right ☐ Down

Did you see the impact coming?: ☐ Yes ☐ No

Were the brakes applied?: ☐ Yes ☐ No

Was the seat adjustment altered after impact?: ☐ Yes ☐ No

What was the speed of your vehicle at impact?: ☐ Full Stop ☐ Slowing ☐ Accelerating

Did any part of your body strike anything in the car?: ☐ Yes ☐ No If yes, please describe: ____________

____

____

Did your car hit any other object?: ☐ Yes ☐ No If yes, please describe: ______________________

____

____

Were there any unusual road conditions?: ☐ Yes ☐ No If yes, please describe: ______________________

____

____

Did you go to the Hospital/Emergency Room or any other facility?: ☐ Yes ☐ No
If yes, please describe visit and what was done:

____

____

____

Have you been in any previous accidents?: ☐ Yes ☐ No If yes, please describe: ______________________

____

____

Auto Injury Questionnaire

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PLEASE CHECK ALL OF THE SYMPTOMS YOU HAVE HAD SINCE THE ACCIDENT

Severity: Rate the the severity of the pain as a 1-10 (1 = low, 10 = high)
Duration: Intermittent = 0-25%, Occasional = 25-50%. Frequent = 50-75%, Constant = 75-100%
Quality of Pain: Sharp, Dull Ache, Deep Ache, Burning, Numbing, Tingling, Left or Right or Both

HEAD:

0-10:	*%*		
_______	_______	Headaches	______________________________
_______	_______	Blurred Vision	______________________________
_______	_______	Loss of Consciousness	______________________________
_______	_______	Bruising	______________________________
_______	_______	Dizziness	______________________________
_______	_______	Cuts/Scrapes/Bruises	______________________________
_______	_______	Fainting	______________________________
_______	_______	Confusion	______________________________
_______	_______	Memory Loss	______________________________
_______	_______	Coordination Problems	______________________________
_______	_______	Balance Problems	______________________________
_______	_______	Face Pain	______________________________
_______	_______	Nose Pain	______________________________
_______	_______	Tooth Pain	______________________________
_______	_______	Jaw Pain	______________________________

NECK AND SHOULDERS:

0-10:	*%*		
_______	_______	Neck Pain	______________________________
_______	_______	Neck Stiffness	______________________________
_______	_______	Pain on Top of Shoulders	______________________________
_______	_______	Pain in Shoulder Joint	______________________________
_______	_______	Pain radiating into arms/hands/fingers	______________________________
_______	_______	Numbness	______________________________
_______	_______	Cuts/Scrapes/Burns	______________________________
_______	_______	Bruising	______________________________
_______	_______	Damage to discs	______________________________
_______	_______	Sleeping Problems	______________________________

Auto Injury Questionnaire

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ARMS/HANDS/FINGERS

0-10: **%**

_______ _______ Upper Arm Pain ____________________
_______ _______ Broken Arm ____________________
_______ _______ Elbow Pain ____________________
_______ _______ Ligament Damage ____________________
_______ _______ Pain in Forearm ____________________
_______ _______ Broken Bones Wrist/Hand/Fingers ____________________
_______ _______ Cuts/Scrapes/Burns ____________________
_______ _______ Bruising ____________________
_______ _______ Tingling in Arm/Hands ____________________

BACK:

0-10: **%**

_______ _______ Upper Back Pain ____________________
_______ _______ Middle Back Pain ____________________
_______ _______ Lower Back Pain ____________________
_______ _______ Radiating Pain into Legs/Feet ____________________
_______ _______ Damage to Discs ____________________
_______ _______ Cuts/Scrapes/Burns ____________________
_______ _______ Bruising ____________________
_______ _______ Numbing/Tingling ____________________

LEGS/FEET/TOES

0-10: **%**

_______ _______ Upper Leg Pain ____________________
_______ _______ Broken Leg ____________________
_______ _______ Knee Pain ____________________
_______ _______ Ligament Damage ____________________
_______ _______ Bruising ____________________
_______ _______ Cuts/Scrapes/Burns ____________________
_______ _______ Lower Leg Pain ____________________
_______ _______ Foot/Toe Pain ____________________
_______ _______ Numbing/Tingling ____________________

Auto Injury Questionnaire

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EMOTIONAL/PSYCHOLOGICAL

0-10: ***%***

_______ _______ Fear of Driving ______________________________

_______ _______ Depression ______________________________

_______ _______ Irritable ______________________________

_______ _______ Unable to Cope ______________________________

_______ _______ Changes in relationships ______________________________

OTHER:

____

____

____

____

Describe how the accident/injury occurred?

____

____

____

____

____

____

Describe your condition(s)?

____

____

____

____

____

____

List any other Doctors, Hospitals, or other Health Care Providers you have seen for this condition, including their contact information. (Names, Addresses, Phone Numbers, etc..)

____

____

____

____

____

____

Auto Injury Questionnaire

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Describe how your life has changed since the accident/injury? (examples - no longer to engage in athletics, difficulty with personal care, can not care for your family as well, etc..)

____
____
____
____
____
____

List all insurance companies that may be involved, along with phone numbers, claim numbers, ID numbers, contact person. (if applicable, automobile insurer, health insurer, disability insurer, homeowners, etc..)

____
____
____
____
____
____

Have you had to miss work due to your injuries? ☐ Yes ☐ No

Have you lost income due to your injuries? ☐ Yes ☐ No

Job / Job Title: ______________________________

Job Duties: ______________________________
____
____

Patient Health Questionnaire - PHQ

Paradise Village Chiropractic Center
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Patient Name ______________________ ***Date*** ______________

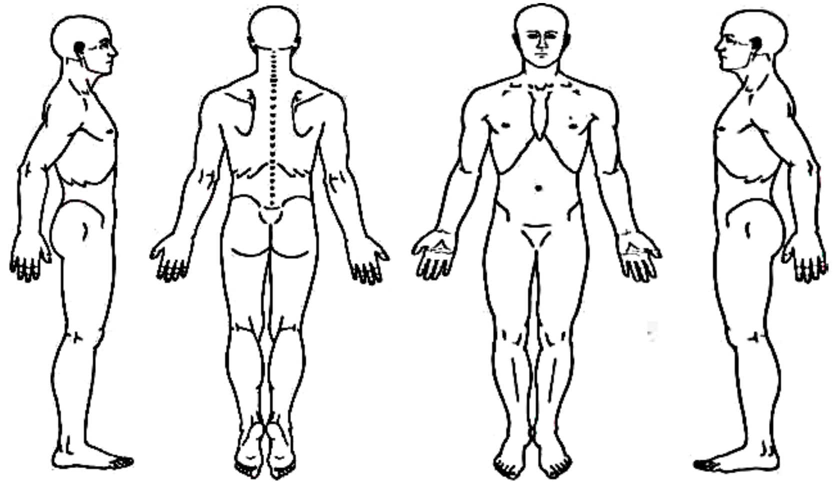
1. Describe your symptoms ______________________

a. When did your symptoms start? ______________________

b. How did your symptoms begin? ______________________

2. How often do you experience your symptoms?
- ○ Constantly (76-100% of the day)
- ○ Frequently (51-75% of the day)
- ○ Occasionally (26-50% of the day)
- ○ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?
- ○ Sharp ○ Shooting
- ○ Dull ache ○ Burning
- ○ Numb ○ Tingling

4. How are your symptoms changing?
- ○ Getting Better
- ○ Not Changing
- ○ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

7. In general would you say your overall health right now is...

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

8. Who have you seen for your symptoms?

○ No One ○ Chiropractor ○ Medical Doctor ○ Physical Therapist ○ Other

a. What treatment did you receive and when? ______________________

b. What tests have you had for your symptoms and when were they performed?

○ Xrays *date:* ________ ○ CT Scan *date:* ________
○ MRI *date:* ________ ○ Other *date:* ________

9. Have you had similar symptoms in the past? ○ Yes ○ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

○ This Office ○ Chiropractor ○ Medical Doctor ○ Physical Therapist ○ Other

10. What is your occupation?

○ Professional/Executive ○ Laborer ○ Retired
○ White Collar/Secretarial ○ Homemaker ○ Other
○ Tradesperson ○ FT Student

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

○ Full-time ○ Self-employed ○ Off work
○ Part-time ○ Unemployed ○ Other

Patient Signature ______________________ ***Date*** ______________

Patient Health Questionnaire - page 2

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Patient Name ______________________ ***Date*** ______________

What type of regular exercise do you perform? ○ None ○ Light ○ Moderate ○ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet, Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Condition
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	Condition
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	Condition
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS
Females Only		
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	
Other Health Problems/Issues		
○	○	
○	○	
○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ ______________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

List all the surgical procedures you have had and times you have been hospitalized:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Patient Signature ______________________ ***Date*** ______________

Provider's Additional Comments

____

____

____

Doctors Signature ______________________ ***Date*** ______________