Goodyear Chiropractic

Welcome *v1.1*

11. W. Van Buren Avondale, Az 85323
(623)932.4060 (623)932.4417 fax

Name _____ Date of Birth _____

SSN _____ Gender Male Female

Address _____City _____ State ___ Zip ____

Home Phone _____ Cell _____ Other _____

Marital Status: Single Married Divorced Widow

Emergency Contact _____ Phone _____ Relation _____

Email _____

Do we have your permission to e-mail / text you No Yes _____

Initial

How did you hear about us? Thank you for being as detailed as possible.

- **Friend _____**
- **Internet:** Google Facebook Yelp **_____**
- **Drive-by Street sign**
- **Treated here before**
- **Massage Therapist**
- **News Paper:** West Valley View Buckeye Star **_____**
- **Other _____**

Goodyear Chiropractic

Auto Accident Intake *v 3.3*

When did the accident occur Date

Which were you Driver Front Passenger Rear Passenger Pedestrian

Your vehicle make and mode Car Truck SUV _____

Vehicle that hit you Car Truck SUV _____

Occurred at Intersection Parking Lot Freeway Town _____

What direction were you headed Northbound Eastbound Westbound South

At impact, was your vehicle Parked Stopped Slowing _____

When Dawn Morning Afternoon Dusk Night _____

Driving conditions Normal Dry Stormy Wet Wind _____

Where was the impact Driver side Passenger side Front Rear _____

Did you hit another car or object after 1st impact No Another Car _____

Body hit the vehicle interior Head Face L / R Shoulder Chest L / R Knee

Where were you looking at time of impact Fwd Rear Left Right Up Down

Driver: which hands were on the steering wheel Both Right Left None

Driver: which foot was on the brake Right Left Both Neither

Head restraint position Middle High Low No Head Restraint

Air bag deployed None Steering Wheel Driver Side Passenger Side

Were you wearing a seat belt Yes No Child Restraint

What doors did not open Rear Hatch Trunk All doors opened freely
Front Driver Side Front Passenger Rear Driver Side Rear Passenger Side

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Hospitalized Abrazo West Banner Estrella Dignity Urgent Care
Other_____

Treatment Medications X-Ray CT Scan Neck Braces Other:_____

Medications Ibuprofen Flexeril Oxycodone Percocet Tylenol Advil Aleve
Other_____

Did you see your PCP When _____ Dr. _____

Home care done Over the Counter Meds Ice Heat Rest Avoid Activity
_____ Followed instructions of ER Followed instructions of PCP

Occupation_____**Missed Days:** _____ **Light Duty:** Yes No

How did you feel before your accident No pain _____

Do you have any serious pre-existing neck or back conditions No Yes

Have you been in a previous car accident When _____ Never

Were you hurt Yes No **Received medical care** Yes No

Released pain free Yes No

Daily Habits Smoking 0 1 2 3 Alcohol 0 1 2 3 Exercise 0 1 2 3
0 =none 1 = a little 2= moderate 3 = a lot

Dominant Hand Left Right

Circle Where You Are Having Symptoms

Neck Pain	Left / Right Arm Numb	Mid Back Pain
Low Back Pain	Left / Right Leg Numb	Left / Right Sciatica
Headache	Vertigo	Short Term Memory Loss
Left / Right Blurry Vision	Left / Right Ear Ringing	Left / Right Jaw Pain
Left / Right Shoulder Pain	Left / Right Elbow Pain	Left / Right Wrist Pain
Left / Right Hand Pain	Left / Right Arm Pain	Left / Right Arm Cuts/Bruise
Left / Right Hip Pain	Left / Right Knee Pain	Left / Right Ankle Pain
Left / Right Foot Pain	Left / Right Leg Pain	Left / Right Leg Cuts/Bruise
Left / Right Rib Pain	Chest Pain	Stomach Pain

Pain Level 3 4 5 6 7 8 9 10

Type Aching Sharp Cramping Radiating Stiff Spasm Burning Tight Tingling

Freq. Constant Frequent Worse in Morning Worse at night Worse in Afternoon

Which Activities Aggravate Your Condition

Neck Movement	Driving	Lifting	Reaching
Back Movement	Sitting	Standing	Walking
House Chores	Yard Work	Bending	Sleeping
Using Restroom	Coughing	Sneezing	Sex

Other:

Circle Any Recent Change in the Following Functions

Concentration	Forgetfulness	Memory Loss	Fatigue
Weight Changes	Night Sweats	Convulsion	Fainting
Rash / Redness	Hair Change	Nail Change	Itching
Absence of Smell	Nose Pain	Nose Bleeds	Anxiety
Hearing Trouble	Ear Pain	Mood Swing	
Change in Taste	Mouth Sores	Mouth Bleeding	
Difficulty Breathing	Cough	Wheezing	
Heart Murmurs	Palpitations	Depression	
Swollen Arms	Swollen Legs	Blue Arms	Blue Legs
Appetite Change	Digestive Changes	Impotence	
Inability to Urinate	Frequent Urination	Painful Urination	
Heat Intolerance	Cold Intolerance	Tremors	

Females: Are you pregnant Not Sure Yes No

Discharge of Breast	Breast Lump	Breast Red/Itching	Breast Pain
Irregular Menstruation	Vaginal Pain	Vaginal Bleeding	

Family Illness Father _____ Mother _____ Sibling _____

Circle Any of the Following Disorders that Apply to You

Multiple Sclerosis	Scoliosis	Polio	Kidney	Heart Disease
High Blood Pressure	Cancer	Asthma	Ulcer	Hay Fever
Low Blood Pressure	HIV	Allergies	STD	Tuberculosis
Emotional Disorder	Epilepsy	Thyroid	Arthritis	Bone Fracture
Rheumatic Fever	Sinusitis	Diabetes	Prostate	Spinal Disc Disease

Surgeries and Medications _____

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Name **Date** **SIGN HERE ►**

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