

Avondale Chiropractic Center
Dr. Matthew Duddy
417 Pennsylvania Avenue
Avondale, PA 19311
610-268-8122
www.avondalechiropractic.com

Auto Accident - New Patient Intake

Title: Dr. Mr. Mrs. Ms. Miss (check one) **Gender:** Male Female **Date:** _____/_____/_____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ - _____ **Work Phone:** (_____) _____ - _____

Cell Phone: (_____) _____ - _____ **Preferred contact method:** Cell Phone Home Phone Work Phone

Date of Birth: ____/____/____ **Age:** _____ **Email:** _____

Primary Doctor: _____ **City:** _____ **State:** _____

Race: (check one)

White Black/African American American Indian/Alaska Native Other _____ I choose not to specify

Ethnicity: (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language: (check one)

English Spanish Other _____ I choose not to specify

Marital Status: Single Married Other _____ **Is your spouse a patient in the clinic?** Yes No

Spouse Data:

First Name: _____ **Middle:** _____ **Last Name:** _____

Home Phone: (_____) _____ - _____ **Cell Phone:** (_____) _____ - _____

Patient Employer Data:

Employment Status: Employed FT/ PT Student FT/ PT Retired Homemaker Unemployed

Employer Name: _____

Address Line: _____ **City:** _____ **State:** _____

Job Title/Position: _____

Emergency Contact:

Contact Name: _____ **Relationship:** _____

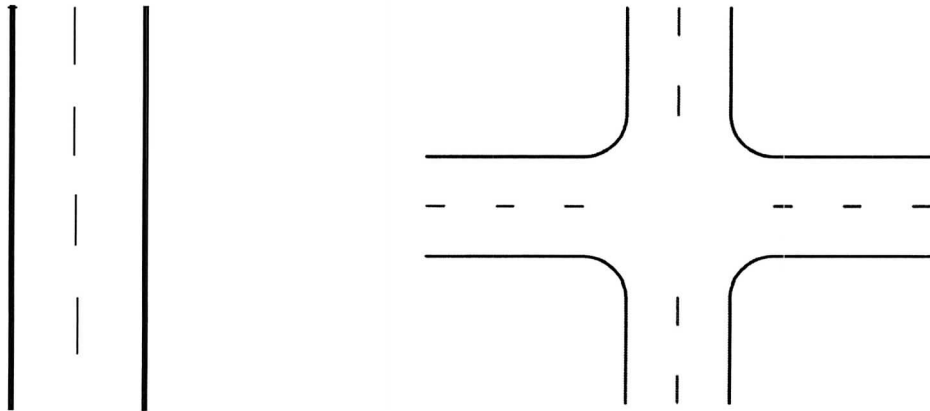
Phone: (_____) _____ - _____

Date of Injury/Accident: _____ Location(What state did it occur?) _____

Do you have an attorney? Yes No If yes, who? _____

IN YOUR OWN WORDS, PLEASE DESCRIBE HOW THE ACCIDENT OCCURED:

Please illustrate how the accident occurred using one of the diagrams:



Point of Impact:

- | | | | |
|--------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Front | <input type="checkbox"/> Driver Front | <input type="checkbox"/> Passenger Front | <input type="checkbox"/> Rear |
| <input type="checkbox"/> Driver Side | <input type="checkbox"/> Passenger Side | <input type="checkbox"/> Passenger Rear | <input type="checkbox"/> Driver Rear |

Current Complaints:

Please mark where your pain/symptoms are:



Patient Name: _____

Date: _____

Please grade your pain on a scale of 0-10:
[0= No Pain, 10= Extreme Pain]

Choose how frequent the pain is present:

Neck: 0 1 2 3 4 5 6 7 8 9 10

Seldom - Intermittent - Frequent - Constant

Upper/Mid Back: 0 1 2 3 4 5 6 7 8 9 10

Seldom - Intermittent - Frequent - Constant

Lower Back: 0 1 2 3 4 5 6 7 8 9 10

Seldom - Intermittent - Frequent - Constant

_____ 0 1 2 3 4 5 6 7 8 9 10

Seldom - Intermittent - Frequent - Constant

Area(s) of complaint:

1. _____ 3. _____
2. _____ 4. _____

Circle which ones describe your symptoms:

- dull
- sharp
- throbbing
- burning
- deep
- aching
- tingling
- stabbing
- cramping
- numbness
- radiating
- stiffness

Other symptoms: _____

Can you go to sleep without problems? Yes No

Do you awaken because of pain? Yes No

If yes, where is the pain that wakes you up? _____

Injury History General:

Was the crash on-the-job? Yes No

You were: Driver Front Seat Passenger L-M-R Rear Seat Passenger Pedestrian

Motorcycle Operator Motorcycle Passenger Other: _____

Vehicle Driven By: _____

Your Vehicle (year/make/model): _____

Other Vehicle (year/make/model): _____

If Driver:

How many hands were on the wheel? : One on wheel Two on wheel None

Were the brakes applied? Yes No

Your Estimated Speed at Moment of Crash:

Stopped

Slow (Example: Parking Lot/Stop Light)

Moderate (Example: Neighborhood)

Fast (Example: Highway)

Time of Day: Daylight Dawn Dusk Dark

Road Conditions: Dry Damp Wet Snow Ice Other: _____

What was the position of the top of your headrest? :

Middle of neck Middle of head None Even with the top of the head Even with the bottom of the head

If adjustable, did your headrest move due to the crash? Yes No Don't Remember

Did your seat move or change position? Yes: Base, Whole Seat, Seat Back No Don't Remember

Did your seat break? Yes No

Lap Belt: Wearing Not Wearing

Shoulder Belt: None Wearing Not Wearing Don't Know

Patient Name: _____

Date: _____

Did the airbag deploy? Yes No

If yes, were you struck by the air bag? Yes No What body part? _____

Did you strike anything in the vehicle? Yes No

If yes, what? Wheel Windshield Armrest Dashboard Side Window Airbag Side Door

Were you aware of impending crash? Yes No

Did you brace yourself for impact? Yes No

Direction of your head: Turned right Turned left Straight ahead Looking up Looking down

Did your head impact anything? Yes No Don't Know

Are you experiencing any? Mental Confusion Memory Loss Depression/Mood Swings Decrease Libido
 Distractibility Light Headedness

Other part of body injured? (Please list in order of severity.)

1. _____ 3. _____

2. _____ 4. _____

During the crash:

Did the vehicle strike any objects after crash? Yes No

If yes, please describe?

Were you dazed? Yes No

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

Damage to your vehicle: Mild Moderate Extensive Totaled Unknown

Were police on the scene? Yes No If yes, report made? Yes No

After the crash:

Immediately after the accident, did you experience any of the following:

Headaches Neck Pain Mid Back Pain Shoulder/Arm Pain

Low Back Pain Hip/Leg Pain Dizziness Nausea

Confusion Disorientation Other: _____

When did symptoms first appear? _____ (hours)

Where did you go after the crash? Work Hospital Home Other: _____

Emergency Department:

Hospital name: _____ DATE: _____

Mode of transportation: _____

Imaging / testing performed? Yes No

If yes, please list type (X-ray, MRI, CT, Lab work, EMG, etc.) location and date taken:

1. _____ DATE: _____

2. _____ DATE: _____

3. _____ DATE: _____

Results: _____

Medication prescribed: _____

Other treatments: _____

Follow-up instructions: _____

Self-assessed percent improvement as of today: (list for separate areas)

Area _____ % Improved: _____

Area _____ % Improved: _____

Area _____ % Improved: _____

Patient Name: _____

Date: _____

Any prior history of current complaints? Yes No

If yes, please describe episodes with dates: _____

Prior treatment by a chiropractor for these? Yes No If yes, please list who and when:

1. _____
2. _____

Circle the activities that aggravate your condition:

- sitting
- standing
- walking
- bending
- stooping
- lifting
- sleeping
- sneezing
- coughing
- straining
- reaching
- twisting
- looking up
- looking down
- movement
- rest
- lying face down
- driving
- typing
- scooping
- house chores
- exercise
- lying face up
- stair stepping

Other aggravating factors: _____

Circle activities that relieve your condition:

- sitting
- standing
- lying
- knees bent up
- support
- no movement
- movement
- heat
- ice
- topical gel
- ibuprofen
- medication
- rest
- stretching/exercising
- adjustments

Other relieving factors: _____

General Information:

Handedness: L R Both

Tobacco Use: Current Every Day Smoker Sometimes Smoker Former Smoker Never been a Smoker

What is your level of interest in quitting smoking?
 0 (No Interest) 1 2 3 4 5 6 7 8 9 10 (Very Interested)

Alcohol Use: None Social Moderate Heavy

Have you ever been disability rated? Yes No If yes, for what? _____

Treatment History:

Any prior Doctor seen for this condition? Yes No

1. Doctor Name: _____ Specialty: _____

Date seen: _____ Referred by: _____

Treatment type: _____

Currently treating? Yes No Did treatment help you? Yes No

Referred to another Provider? _____

Notes: _____

2. Doctor Name: _____ Specialty: _____

Date seen: _____ Referred by: _____

Treatment type: _____

Currently treating? Yes No Did treatment help you? Yes No

Referred to another Provider? _____

Notes: _____

Patient Name: _____

Date: _____

Current Medical History:

Current Health Problems (Heart Disease, Diabetes, High Blood Pressure, etc): None

Current Medications Taken:

Vitamins/Supplements None See Separate List

Are you currently pregnant? Yes No If so, what is your due date? _____

Have you had children? Yes No If so, how many children have you had? _____

List any known allergies you have to any medications: No known allergies

- 1. _____ 3. _____
- 2. _____ 4. _____

Has any doctor diagnosed you with High Blood Pressure? Yes No

Has any doctor diagnosed you with Diabetes presently? Yes No

If yes, what kind? Type 1 Type 2 If yes, was most recent hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

Past Medical History:

Injuries to Head, Neck, or Back, including Motor Vehicle Accidents or Work Injuries:

Surgeries (Dates & Type): _____

Fractures (Dates & Type): _____

Family History: please circle and check all that applies

Diabetes	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Heart Disease	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
High Cholesterol	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Hypertension	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Osteoporosis	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Cancer (specify): _____	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son
Psychological Disorders	Yes	No	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/> Daughter	<input type="checkbox"/> Son

No known Conditions

Patient Signature: _____ Date: _____

To be performed by clinic staff: Height: _____ in Weight: _____ lbs BP: _____/_____ Pulse: _____ bpm

Patient Name: _____

Date: _____

Please complete this to the best of your ability, if you have any questions, see Brooke.

Pain Levels 1 – 10 (one little pain, 10 extreme pain)

Neck – 1 2 3 4 5 6 7 8 9 10

R Shoulder - 1 2 3 4 5 6 7 8 9 10

R Elbow - 1 2 3 4 5 6 7 8 9 10

R Wrist - 1 2 3 4 5 6 7 8 9 10

Mid Back - 1 2 3 4 5 6 7 8 9 10

R Hip - 1 2 3 4 5 6 7 8 9 10

R Knee - 1 2 3 4 5 6 7 8 9 10

R Ankle - 1 2 3 4 5 6 7 8 9 10

L Shoulder - 1 2 3 4 5 6 7 8 9 10

L Elbow - 1 2 3 4 5 6 7 8 9 10

L Wrist - 1 2 3 4 5 6 7 8 9 10

Low Back - 1 2 3 4 5 6 7 8 9 10

L Hip - 1 2 3 4 5 6 7 8 9 10

L Knee - 1 2 3 4 5 6 7 8 9 10

L Ankle - 1 2 3 4 5 6 7 8 9 10

Please answer the questions below and provide any additional information you believe necessary to your care.

Do you experience numbness or tingling? _____

Do you get Headaches? _____

Any dizziness or vertigo? _____

Do you use heat or ice? _____

Do you wear a back brace? _____

Any recent MRI or X-ray? _____

What makes your pain worse? _____

What makes your pain feel better? _____

Does Chiropractic care help? _____

Does your pain radiate from one area and travel to another? If yes where? _____

How would you describe your pain? (ex. burning, stabbing, shooting, pinching, achy, tight, stiff, sharp, dull)

Do you have a family history of back problems (mom, dad, sister, brother)? _____

Do you have any bulging discs or herniations? _____

Do you exercise, or do you stretch? _____

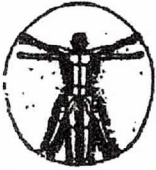
Who is your primary care physician? _____

When did the pain start and How? _____

Have you ever been seen by a Chiropractor before? _____

Are you vaccinated for COVID-19? Yes / No

Any recent falls? _____ When was your last auto accident? _____



Avondale Chiropractic Center

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STATEMENT OF FINANCIAL UNDERSTANDING

Patients with chiropractic insurance will be expected to pay any deductible or coinsurance amount they owe on the date of service. I understand that if there is a problem with my insurance I will pay Avondale Chiropractic for any outstanding charges. Avondale Chiropractic has no control over the payment of your claim by your insurance company. If you do not carry insurance we ask that all charges be paid at the time of service.

Auto accident and workers compensation claims will be billed entirely to the insurance company. However it is your responsibility to obtain the proper forms and notify your employer and /or insurance company of the injury/accident. If the claim should be denied or rejected I understand that I'm responsible for payment of all charges.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their own PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained for one time for all the subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your own security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures and our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with a privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient or authorize signature _____ Date _____

**Avondale Chiropractic Center
417 Pennsylvania Avenue
P.O. Box 297
Avondale, PA 19311**

**NOTICE OF PRIVACY PRACTICES
Per HIPPA REGULATIONS**

Consent for Purposes of Treatment, Payment and Healthcare Operations

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I acknowledge that Avondale Chiropractic Centers "Notice of Privacy Practices" has been provided to me. I understand I have the right to review Avondale Chiropractic Center Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performances of healthcare operations at Avondale Chiropractic Center. The Notice of Privacy Practices is also provided on request at the main administration desk. This notice of Privacy Practices also describes my rights and Avondale Chiropractic Center duties with respect to my protected health information. Avondale Chiropractic Center reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by calling the office and requesting a revised copy to be sent via mail or may request a copy at the time of my next scheduled appointment.

Signature on file form

- 1. I authorize use of this form on all my insurance submissions.**
- 2. I authorize release of information to all insurance companies related to my care at Avondale Chiropractic Center**
- 3. I authorize release of all medical / health information from any other provider I have used previously to Avondale Chiropractic Center and any agent working on their behalf.**
- 4. I authorize Avondale Chiropractic Center and any agent working on their behalf to obtain payment from my insurance company and / or attorney.**
- 5. I authorize payment to be made directly to Avondale Chiropractic Center.**
- 6. I permit a copy of this authorization to be used in place of the original.**
- 7. I permit Avondale Chiropractic Center and any agent working on their behalf to contact me by means of the home, work and / or cell phone number(s) I have provided on the patient information form.**
- 8. I permit Avondale Chiropractic Center and any agent working on their behalf to contact me via written communication to my home address given on the patient information form.**

I have received the Notice of Privacy Practices and have reviewed it and I have reviewed the signature on file form.

Description of Patient Representative's Authority

Signature of Patient or Patient Representative/Date

Name of Patient or Patient Representative

Avondale Chiropractic Center Staff Witness / Date