Chiro Health Pro LLC
Dr. Martin Petrovic, DC
chirohealthpro.com

Mobile Practice
Portland, OR 97230
503-809-0800

RETURN THIS FORM TO BILLING OFFICE

AUTO COLLISION INFORMATION

Patient Name: _____

Date of Collision: _____ Today's Date: _____

INSURANCE INFORMATION

Name of Policy Holder: _____

Name of Policy Holder's Insurance Company: _____

Phone Number: _____

CLAIMS OFFICE

Address: _____

Claim Representative's Name: _____

Phone Number: _____ Fax: _____

Claim Number: _____ Email: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Chiro Health Pro clinics to furnish my records to the insurance company or an attorney for the purpose of obtaining payment on my account for the service(s) provided to me. In addition, the undersigned hereby authorizes payment directly to Chiro Health Pro clinics for all medical benefits otherwise payable to the undersigned or the patient.

I understand that I am responsible for all charges incurred at Chiro Health Pro clinics regardless of my insurance coverage.

Patient/Guardian Signature: _____ Date: _____

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Auto Collision Questionnaire

Patient Name: _____ Today's Date: _____

Date of Collision: _____ Time of Collision: _____: _____ ☐ AM ☐ PM

Location of Collision: _____

Were you: Driver / Passenger (circle one)

Were you wearing a seat belt? ☐ Yes ☐ No
With a shoulder harness? ☐ Yes ☐ No

Your car: _____
Year Make Model

Other Car: _____
Year Make Model

☐ Front impact ☐ Side impact ☐ Rear impact ☐ Non-collision: _____

Describe what happened to your body upon impact: _____

_____

Estimated speed of **your** car: _____ mph ☐ Speeding up ☐ Braking ☐ Totally stopped

Estimated speed of **other** car: _____ mph ☐ Speeding up ☐ Braking ☐ Totally stopped

Did you brace for impact? ☐ Yes ☐ No Was your foot on the brake: ☐ Yes ☐ No

Describe your body position at impact? ☐ head forward ☐ head turned left ☐ head turned right
☐ body forward ☐ body turned left ☐ body turned right
☐ other: _____

Did any part of your body strike the inside of the car? ☐ No ☐ Yes: _____

Any cuts, bruises or abrasions? ☐ No ☐ Yes: _____

Hit your head or lose consciousness? ☐ No ☐ Yes: _____

Were the police summoned? ☐ No ☐ Yes Was an ambulance summoned? ☐ No ☐ Yes
Did you go to the hospital? ☐ No ☐ Yes Were x-rays taken? ☐ No ☐ Yes

Have you been examined and/or treated for your injuries? ☐ No ☐ Yes (please describe):

_____

_____

Circle all that apply: Emergency room / X-rays / CT / MRI / Pain Medication / Muscle Relaxers / NSAIDS

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Questionnaire Continued

Patient Name: _____ Today's Date: _____

How did you feel immediately after the collision? _____

_____

Could you move all parts of your body? ☐ Yes ☐ No: _____

Could you exit the car and walk unaided? ☐ Yes ☐ No: _____

How did you feel **that night**? _____

_____

How did you feel over the **next few days**? _____

_____

Check any symptoms that have occurred since the collision:

☐ headache	☐ neck pain/stiffness	☐ mid back pain	☐ low back pain
☐ dizziness	☐ numbness (arms/hands)	☐ shortness of breath	☐ numbness (legs/feet)
☐ fatigue	☐ sleeping problems	☐ nervous/anxious	☐ tension

☐ Other: _____

Have you missed time for work? ☐ No ☐ Yes : missed full time work: from _____ to _____

missed part time work: from _____ to _____

Are your work activities restricted as a result of this injury? ☐ No ☐ Yes: _____

_____

Did you have any physical complaints just before the collision? ☐ No ☐ Yes: _____

_____

Check any symptoms that you had ***BEFORE*** the collision:

☐ headache	☐ neck pain/stiffness	☐ mid back pain	☐ low back pain
☐ dizziness	☐ numbness (arms/hands)	☐ shortness of breath	☐ numbness (legs/feet)
☐ fatigue	☐ sleeping problems	☐ nervous/anxious	☐ tension

☐ Other: _____

_____

Patient/Guardian Signature: _____ Date: _____

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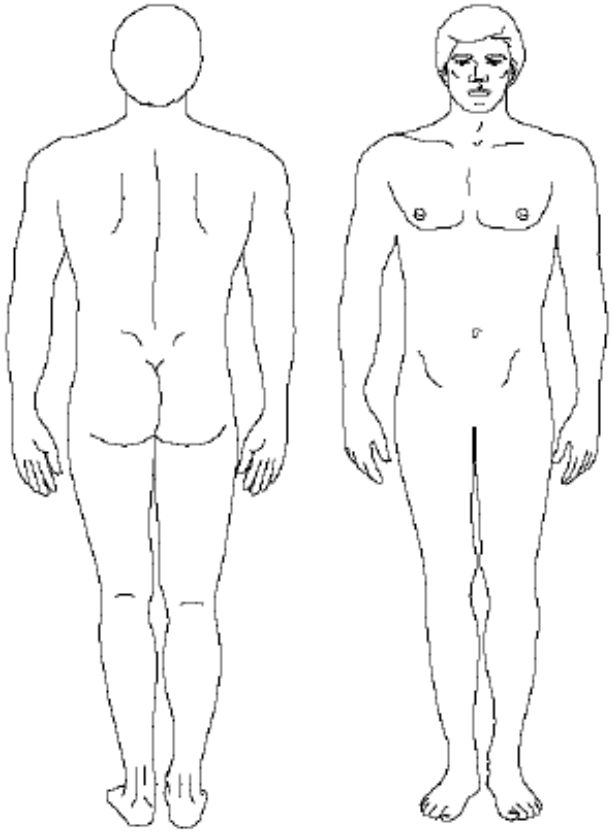
Patient Initial Intake

Patient Name: _____ DOB: _____ Date: _____

Describe your symptoms: _____
_____
_____
_____

Indicate the location of your symptoms:



Describe any activities affected by your symptoms:
_____
_____

When did your symptoms begin? _____
_____

Are you symptoms getting worse? ☐ No ☐ Yes
Does it keep you from working? ☐ No ☐ Yes
Does it keep you from sleeping? ☐ No ☐ Yes

Have you seen a chiropractor before? ☐ No ☐ Yes
Are you under the care of a physician? ☐ No ☐ Yes
Name of physician: _____

Please list current medications and reasons for taking them:
_____
_____

Have you ever experienced:	No	Yes	If yes, briefly explain:
☐ broken bone	☐	☐	_____
☐ hospitalization/surgery	☐	☐	_____
☐ strains/sprains	☐	☐	_____
☐ fallen/struck unconscious	☐	☐	_____
☐ auto collision/work injury	☐	☐	_____

Please list any other health conditions (10 years): _____
_____
_____

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine	Cups/day _____
☐ Heavy	☐ Heavy Labor	☐ Stress level	Reason _____

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Review of Systems

Patient Name: _____ DOB: _____ Date: _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please indicate all CURRENT or PAST conditions. To be responsible for your case, we need your complete health history.

C = Current problem P = Past problem

C	P	Muscle / Joint
☐	☐	Neck pain, stiffness
☐	☐	Pain b/t shoulders
☐	☐	Low back pain
☐	☐	Sciatica
☐	☐	Painful tailbone
☐	☐	Poor posture
☐	☐	Spinal curvature
☐	☐	Foot trouble
☐	☐	Swollen joints
☐	☐	Bursitis

C	P	Pain
☐	☐	Headache
☐	☐	Eye
☐	☐	Ear
☐	☐	Abdomen
☐	☐	Chest
☐	☐	Shoulders
☐	☐	Upper Arm
☐	☐	Elbows
☐	☐	Forearm
☐	☐	Hand
☐	☐	Hips
☐	☐	Thigh
☐	☐	Knee
☐	☐	Shin
☐	☐	Ankle
☐	☐	Feet

C	P	Numbness
☐	☐	Shoulders
☐	☐	Upper Arm
☐	☐	Forearm
☐	☐	Thigh
☐	☐	Shin / calf
☐	☐	Feet
☐	☐	Hands

C	P	General
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Concussion
☐	☐	Allergy
☐	☐	Skin rash
☐	☐	Enlarged glands

C	P	Cardiovascular
☐	☐	Hardened arteries
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Pain over heart
☐	☐	Poor circulation
☐	☐	Rapid heartbeat
☐	☐	Slow heartbeat
☐	☐	Swelling of ankles

C	P	Gastrointestinal
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Jaundice
☐	☐	Liver trouble
☐	☐	Nausea
☐	☐	Vomiting

C	P	Genitourinary
☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Lose bladder control
☐	☐	Kidney infection
☐	☐	Painful urination
☐	☐	Prostate trouble

C	P	WOMEN ONLY:
☐	☐	Congested breasts
☐	☐	Lumps in breast
☐	☐	Menstrual pain
☐	☐	Irregular cycle
☐	☐	Excessive flow
☐	☐	Hot flashes
☐	☐	Menopause

C	P	Respiratory
☐	☐	Chronic cough
☐	☐	Difficult breathing
☐	☐	Spit up blood

Check any conditions you have presently OR have had in the past:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Edema
- ☐ Emphysema
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

Pacemaker (or other medical implant): ☐ No ☐ Yes **Pregnant**: ☐ No ☐ Yes ☐ Planning

Please list any family history of serious illness (i.e. heart disease, stroke, cancer, diabetes):

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

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New Patient Registration

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: M / F Social Security #: _____ - _____ - _____

Address: _____

Primary Phone: (_____) _____ - _____ ☐ home ☐ cell ☐ work ☐ preferred

Secondary Phone: (_____) _____ - _____ ☐ home ☐ cell ☐ work ☐ preferred

E-mail: _____ ☐ opt-in ☐ opt-out

Employer: _____ Occupation: _____

Primary Physician's Name: _____ Phone: (_____) _____ - _____

Emergency Contact: _____ Phone: (_____) _____ - _____

Address: _____

Next of Kin: ☐ same as emergency ☐ other: _____

Who may we thank for referring you? _____

Patient/Guardian Signature: _____ Date: _____