



**Midvale Chiropractic Orrin C. Smith, DC Chiropractic Physician**  
**1685 W. Valencia #101 Tucson, AZ 85746 (520) 889-9631 Fax (520) 295-0385**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Hour: \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_

Specific Location of Accident: \_\_\_\_\_

**Describe in detail, in your own words, how the accident happened:** \_\_\_\_\_

\_\_\_\_\_

In the accident: Were you the  Driver  Passenger  Pedestrian  Other? \_\_\_\_\_

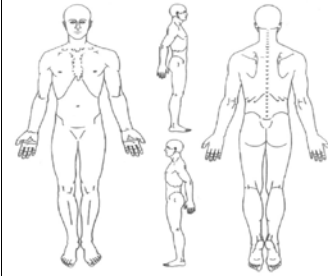
Did your car strike the other vehicle?  Yes  No **Did the other car strike your car?  Yes  No**

Were you struck from:  Behind  Front  Side Impact  Driver's Side  Passenger's Side

Were traffic citations issued to:  You  the Driver of Your Car  the Driver of the Other Car  No Citations Given

Was your car heading:  North  South  East  West on \_\_\_\_\_ (Street/Highway)

Was the other heading:  North  South  East  West on \_\_\_\_\_ (Street/Highway)

<p align="center"><b>Please mark on the diagram to the right the following symbols as they relate to your symptoms:</b></p> <p>SS = spasms                      ST = stiffness          DP = dull pain                    SP = sharp pain          SH = shooting pain            TI = tingling          NU = numbness                 O = Other</p>	
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**CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Middle Back Pain     | <input type="checkbox"/> Lower Back Pain      | <input type="checkbox"/> Ears Ring       |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Lower Back Stiffness | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Neck Stiffness    | <input type="checkbox"/> Bruised Chest        | <input type="checkbox"/> Radiating Pain       | <input type="checkbox"/> Dizziness       |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Bruising Anywhere    | <input type="checkbox"/> Tingling in Legs     | <input type="checkbox"/> Loss of Smell   |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Blurred Vision       | <input type="checkbox"/> Tingling in Arms     | <input type="checkbox"/> Loss of Taste   |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> Any Burns       |
| <input type="checkbox"/> Fainting          | <input type="checkbox"/> Upper Arm Pain       | <input type="checkbox"/> Upper Leg Pain       | <input type="checkbox"/> Any Stitches    |
| <input type="checkbox"/> Muscle Spasms     | <input type="checkbox"/> Lower Arm Pain       | <input type="checkbox"/> Lower Leg Pain       | <input type="checkbox"/> Any Cuts        |

**Have you lost time from work?**  Yes  No: If Yes, Dates: \_\_\_\_\_ to \_\_\_\_\_

Employer: \_\_\_\_\_ Employers Telephone: \_\_\_\_\_

**Did you go to the hospital?**  Yes  No: If Yes, Name of Hospital or E.R.: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Hospitalization: \_\_\_\_\_

Attending E.R. Doctor: \_\_\_\_\_ Treatment Given? \_\_\_\_\_

**DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:**

- |   |  |  |   |
|---|--|--|---|
| Tuberculosis <input type="checkbox"/> Yes   | Lung Disease <input type="checkbox"/> Yes    | Gout <input type="checkbox"/> Yes            | Diabetes <input type="checkbox"/> Yes   |
| Kidney Disease <input type="checkbox"/> Yes | Stomach/Ulcer <input type="checkbox"/> Yes   | Heart Disease <input type="checkbox"/> Yes   | Hepatitis <input type="checkbox"/> Yes  |
| Sciatica <input type="checkbox"/> Yes       | Blood Pressure <input type="checkbox"/> Yes  | Transfusion <input type="checkbox"/> Yes     | Polio / MS <input type="checkbox"/> Yes |
| Colon Disease <input type="checkbox"/> Yes  | Stroke <input type="checkbox"/> Yes          | Cancer <input type="checkbox"/> Yes          | Bleeding <input type="checkbox"/> Yes   |
| Paralysis <input type="checkbox"/> Yes      | Seizures <input type="checkbox"/> Yes        | Arthritis <input type="checkbox"/> Yes       | Asthma <input type="checkbox"/> Yes     |
| Anemia <input type="checkbox"/> Yes         | Thyroid Disease <input type="checkbox"/> Yes | Drug Dependence <input type="checkbox"/> Yes | AIDS <input type="checkbox"/> Yes       |

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**PLEASE CHECK (✓) AS MANY OF THE FOLLOWING STATEMENTS THAT APPLY TO YOUR CASE.**

- I have medical payment (Med-Pay) benefits, either, personally or through the driver of my vehicle.
- I have group health insurance benefits either directly or through my spouse or parents.
- I have retained an attorney.**
- I have not retained an attorney.**
- I have the adverse or third party information available. (Insurance company of the other driver.)

**PLEASE PROVIDE THE APPROPRIATE INSURANCE INFORMATION:**

**1) YOUR AUTOMOBILE INSURANCE CARRIER:** \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_ Insured: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**2) YOUR GROUP HEALTH INSURANCE COMPANY:** \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_ Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Policy #: \_\_\_\_\_ SS#: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER:** \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_ Claims Rep: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Insured: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**4) Attorney:** \_\_\_\_\_ **Legal Assistant:** \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**HIPAA Compliance**

Midvale Chiropractic 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: \_\_\_\_\_