

**Fitwell Chiropractic & Sports Therapy**

14640 N. Tatum Blvd, Ste 7 Phoenix, AZ 85032 O: 602.867.7463 F: 602.867.7800

**PERSONAL HISTORY**

Name: \_\_\_\_\_  M  F Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Married  Single  Widow  Divorced # Children: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Emergency Contact & Phone: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_  FT  PT

Employer: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ PCP Ph: \_\_\_\_\_ Is it OK if we contact them about your care Y N

How did you learn about our office: Yellow Pages Online Mailer Friend Family Co-worker Physician Other

If referred, by whom: \_\_\_\_\_

***ACCIDENT INFORMATION:***

Accident date? \_\_\_\_\_ Were you  Driver  Passenger  Front Seat  Back Seat

Approximate speed of your car? \_\_\_\_\_ The other car? \_\_\_\_\_

Were you wearing your seat belt?  Yes  No

Did you hit anything IN the car?  Yes  No - If so, What did you hit? \_\_\_\_\_

Were you knocked unconscious?  Yes  No - If so, how long? \_\_\_\_\_

Were the police notified?  Yes  No - If so, who was at fault? \_\_\_\_\_

Were you taken to the hospital?  Yes  No - If so, where? \_\_\_\_\_

Were you examined?  Yes  No - X-rayed  Yes  No - Given Medication  Yes  No

Have you seen any one else for this accident?  Yes  No If so, whom? \_\_\_\_\_

What Type of Treatment did you receive? \_\_\_\_\_

Did they:  X-ray  MRI  CT Scan  Other tests - What area(s) \_\_\_\_\_

Given any medications:  Yes  No - If so, what? \_\_\_\_\_

Have you lost anytime from work?  Yes  No - If so, how long? \_\_\_\_\_

Are you back to work?  Yes  No - What do you do? \_\_\_\_\_

Did you have any physical complaints BEFORE this accident?  Yes  No – If so, please describe in detail  
\_\_\_\_\_  
\_\_\_\_\_

In your own words please describe the accident \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe how you felt:  
IMMEDIATELY AFTER the accident \_\_\_\_\_  
LATER that day \_\_\_\_\_  
The NEXT day \_\_\_\_\_

What are your PRESENT complaints or symptoms? \_\_\_\_\_  
\_\_\_\_\_

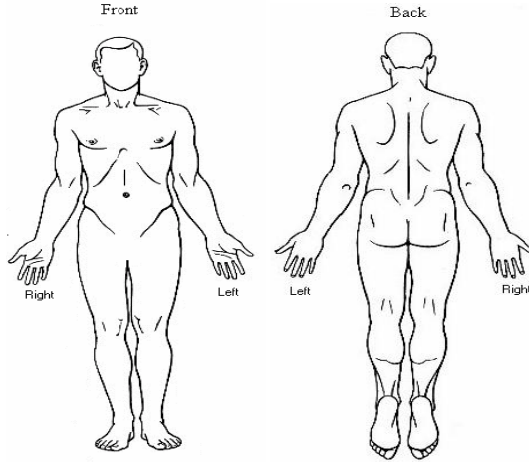
Since the accident are your symptoms:  Improving  Getting worse  Intermittent  Staying the same  
Have you noticed any activity restrictions as a result of this accident?  Yes  No - If so, please describe in detail: \_\_\_\_\_  
\_\_\_\_\_

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Be sure to fill this out **EXTREMELY ACCUTATELY**. Please mark all areas of discomfort or pain on the person figure to the right using the symbols that best describe your symptoms.



- Numb - nn                      Pins & Needles - oo
- Burning - bb                  Stabbing - xx
- Dull ache - dd                Tightness - tt
- Spasm - ss                      Other – describe off to side

|  |  |  |
|--|--|--|
| Please list your reason(s) for this visit or your condition(s) in order of importance:<br><br>1. _____<br>2. _____<br>3. _____<br>4. _____ | Using a scale in which “0” is <u>none</u> (no pain or symptoms) and “10” is <u>severe</u> pain or symptoms(s), <b>circle</b> the number that best reflects your condition:<br>↓ none.....to.....severe ↓<br>0 1 2 3 4 5 6 7 8 9 10<br>0 1 2 3 4 5 6 7 8 9 10<br>0 1 2 3 4 5 6 7 8 9 10<br>0 1 2 3 4 5 6 7 8 9 10 | Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:<br><br><input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%<br><input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%<br><input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%<br><input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100% |
|--|--|--|

List all current medications and SUPPLEMENTS you are taking and for what: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please check YES or NO for ALL of the following regarding your health:**

|  |   |  |
|--|---|--|
| <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> <input type="checkbox"/> Heart Disease / Circulatory Issues<br>(explain) _____<br><input type="checkbox"/> <input type="checkbox"/> Stroke (date) _____<br><input type="checkbox"/> <input type="checkbox"/> Diabetes<br><input type="checkbox"/> <input type="checkbox"/> Hives, Eczema, Rash<br><input type="checkbox"/> <input type="checkbox"/> Unusual Spots / Moles<br><input type="checkbox"/> <input type="checkbox"/> Cancer / Tumor (explain) _____<br><input type="checkbox"/> <input type="checkbox"/> Osteoporosis / Osteopenia (where) _____<br><input type="checkbox"/> <input type="checkbox"/> Temperature / Pressure Sensitivity<br><input type="checkbox"/> <input type="checkbox"/> Broken bones / Fractures: _____<br><input type="checkbox"/> <input type="checkbox"/> Surgeries / Hospitalizations: _____<br><input type="checkbox"/> <input type="checkbox"/> Other health related issues: _____ | <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> Prostate Problems<br><input type="checkbox"/> <input type="checkbox"/> Menstrual Problems<br><input type="checkbox"/> <input type="checkbox"/> Urinary Problems<br><input type="checkbox"/> <input type="checkbox"/> Pregnant? # Weeks _____<br><input type="checkbox"/> <input type="checkbox"/> Taking Birth Control _____<br><input type="checkbox"/> <input type="checkbox"/> STD _____<br><input type="checkbox"/> <input type="checkbox"/> HIV / AIDS Positive<br><input type="checkbox"/> <input type="checkbox"/> Dizziness / Fainting<br><input type="checkbox"/> <input type="checkbox"/> Epilepsy / Seizures<br><input type="checkbox"/> <input type="checkbox"/> History of Head Injury<br><input type="checkbox"/> <input type="checkbox"/> Headaches<br><input type="checkbox"/> <input type="checkbox"/> Bruise easily / Bleeding problems | <p><b>Y N</b></p> <input type="checkbox"/> <input type="checkbox"/> Pain at Night<br><input type="checkbox"/> <input type="checkbox"/> Night Sweats<br><input type="checkbox"/> <input type="checkbox"/> Recent Fever<br><input type="checkbox"/> <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain<br><input type="checkbox"/> <input type="checkbox"/> Thyroid <input type="checkbox"/> Hypo <input type="checkbox"/> Hyper<br><input type="checkbox"/> <input type="checkbox"/> Asthma / Difficulty Breathing<br><input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> <input type="checkbox"/> Corticosteroid Use<br><input type="checkbox"/> <input type="checkbox"/> Stress<br><input type="checkbox"/> <input type="checkbox"/> Wear Contacts<br><b>Last physical-date:</b> _____ |
|--|---|--|

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**Physical/Social History:**

- |  |   |   |   |
|--|---|---|---|
| <i>Exercise</i>                          | <i>Work Activity</i>                      | <i>Habits</i>   | <i>What does your pain effect?</i>                                  |
| <input type="checkbox"/> None            | <input type="checkbox"/> Sitting          | <input type="checkbox"/> <input type="checkbox"/> Smoking-Packs/day _____   | <input type="checkbox"/> <input type="checkbox"/> Work              |
| <input type="checkbox"/> Moderate        | <input type="checkbox"/> Standing/bending | <input type="checkbox"/> <input type="checkbox"/> Alcohol-Drinks/week _____ | <input type="checkbox"/> <input type="checkbox"/> Sleep             |
| <input type="checkbox"/> Heavy           | <input type="checkbox"/> Light labor      | <input type="checkbox"/> <input type="checkbox"/> Caffeine-Drinks/day _____ | <input type="checkbox"/> <input type="checkbox"/> Daily Routines    |
| <input type="checkbox"/> Days/week _____ | <input type="checkbox"/> Heavy labor      | <input type="checkbox"/> <input type="checkbox"/> High stress               | <input type="checkbox"/> <input type="checkbox"/> Recreation        |
|  |   |   | <input type="checkbox"/> <input type="checkbox"/> Sports _____      |
|  |   |   | <input type="checkbox"/> <input type="checkbox"/> Playing with Kids |
|  |   |   | <input type="checkbox"/> <input type="checkbox"/> Driving           |
|  |   |   | <input type="checkbox"/> <input type="checkbox"/> Concentration     |

**Family History:**

- |   |   |
|---|---|
| <i>Mother's Side:</i>   | <i>Father's Side:</i>   |
| <b>Y N</b>  | <b>Y N</b>  |
| <input type="checkbox"/> <input type="checkbox"/> Cancer (type) _____       | <input type="checkbox"/> <input type="checkbox"/> Cancer (type) _____       |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease - Age _____ | <input type="checkbox"/> <input type="checkbox"/> Heart Disease - Age _____ |
| <input type="checkbox"/> <input type="checkbox"/> Stroke - Age _____        | <input type="checkbox"/> <input type="checkbox"/> Stroke - Age _____        |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure       |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis      | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis      |
| <input type="checkbox"/> <input type="checkbox"/> Other _____               | <input type="checkbox"/> <input type="checkbox"/> Other _____               |

I understand and agree that health and accident policies are arrangement between an insurance carrier and myself. Furthermore, I understand that Fitwell Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Fitwell Chiropractic will be credited to my account upon receipt. However, I clearly understand that all services rendered to me are charged directly to me and that I AM PERSONALLY responsible for payment. I also understand that if I suspend or terminate my care and treatment, ANY fees for professional services rendered to me will be immediately due and payable. I also understand and agree to give Fitwell Chiropractic Office, PLLC the POWER OF ATTORNEY to sign any insurance check mailed to the doctor with my name on the check for any services rendered at Fitwell Chiropractic Offices, PLLC I authorize payment of medical benefits to Fitwell Chiropractic Office PLLC for any and all services rendered. I also authorize the release of any information pertinent to my case to any insurance, adjuster, or attorney involved in this case. Furthermore, I have read and understand the Fitwell Chiropractic & Sports Therapy Notice of Privacy Practices.

Name of Person Responsible for Payment (Please Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_