AUTO ACCIDENT AND WORK RELATED INJURY NEW PATIENT REGISTRATION AND HISTORY

*Please Complete **ENTIRE** Form and Return to Front Desk*
Settlement of Patient Financial Responsibility is Expected at Time of Service

PATIENT INFORMATION:

Last:______________________________ First:________________________________ Middle Initial:__________

Date of Birth:______________________ Social Security Number:________________________ Sex: ☐M ☐ F

Phone:_______________________________________ Email Address:_______________________________________

Address:____

City:____ State:______________ Zip Code____________

May we leave a message regarding your care (x-ray, lab results) on your phone: ☐Yes ☐No

May we send electronic messages to your email address on file: ☐Yes ☐No

Would you like to receive text reminders of upcoming appointments: ☐Yes ☐No

Parent or Legal Guardian name (if applicable):____________________________ Relationship:_______________

Emergency Contact:____ Relationship:_______________

Phone:_______________________________________ Email Address:_______________________________________

Address (if different): ____

City:____ State:______________ Zip Code____________

AUTO-ACCIDENT:

Complete this section if your visit is related to injuries sustained during an auto-accident

Date of Accident:____________________ Who Was at Fault:____

Location of Accident:______________________________ Police Report Number:__________________________

Who is Your Auto Insurance Carrier:____

Policy Number:____________________________________ Claim Number:_______________________________

Insurance Adjuster Name:_____________________________ Phone Number:______________________________

Are You Currently Represented by an Attorney: ___ Yes ___No

Attorney Name:____ Attorney Phone Number:____________________

Are You Currently Being Treated by a Chiropractor: ___ Yes ___No

Chiropractor Name:___________________________________ Chiropractor Phone Number:________________

WORK-RELATED INJURY:

Complete this section if your visit is as a result of a work related injury

Date of Injury:___________________ Employer Name:_____________________________________

Employer Address:____

City:____________ State:________ Zip Code_________ Phone:_____________________________

Occupation:_____________________________ Supervisors Name:__________________________

Are You Currently Represented by an Attorney: ___ Yes ___No

Attorney Name:_____________________________________ Attorney Phone Number:__________________

Are You Currently Being Treated by A Chiropractor: ___ Yes ___No

Chiropractor Name:_________________________________ Chiropractor Phone Number:_______________

Acknowledgements:

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgment Form (§164.520(a): I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been given an opportunity to review and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I further understand that this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested

FINANCIAL AGREEMENT: I understand that I am financially responsible and agree to pay all of the charges associated with my care. I understand that I am responsible for payment at the time the service is provided and, if required agree to enter into a separate financial contract.

CONSENTS, DISCLOSURES AND ACKNOWLEDGMENTS: I voluntarily consent to treatment for myself and/or my dependents. I acknowledge that I have been advised of my right to receive copies of any documents and records which Peak Performance Medical, LLC. has in its possession for myself and/or my dependent.

RELEASE OF INFORMATION: I authorize the facility to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges for this treatment, and for quality management, utilization review, transfer, and follow-up purposes. I understand that a copy of this agreement may be used with the same effectiveness as an original.

Signature of Patient:___________________________________ Date:___________________

MEDICAL HISTORY

All Information Obtained Will be Kept in Accordance With Applicable HIPAA Privacy Standards

Name: (Last, First, Mi) ____ ☐M ☐F D.O.B: __________

Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous/Referring Physician: ___________________________________ Date of Last Exam: ____________

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates (if known):

☐ Tetanus _______
☐ Hepatitis _______
☐ Influenza _______
☐ Pneumonia ________
☐ Chickenpox ________
☐ MMR ________ (measles, mumps, rubella)

List any Medical Problems That Other Doctors Have Diagnosed:

1.____ 3. ____
2.____ 4.____

Surgeries:

Year Reason Hospital

_______ ____ ____
_______ ____ ____
_______ ____ ____

Other Hospitalizations:

Year Reason Hospital

_______ ____ ____
_______ ____ ____
_______ ____ ____

Have You Ever had a Blood Transfusion? ☐ Yes ☐ No **If so Appro'x Date of Last Transfusion:**__________

Are you Allergic to any Medications? If so, Please List Allergic Reaction:

Medication Reaction

____ ____
____ ____
____ ____

Are you Allergic to Latex: ☐ Yes ☐ No?

Do you Have Any Other Allergies? If yes, Please explain:____
____

Please list any medications you are currently taking, along with dosage and frequency (including non-prescription medications, vitamins, herbs, or supplements.):

Name	Dosage	Frequency
______________________________	______________	___________
______________________________	______________	___________
______________________________	______________	___________
______________________________	______________	___________
______________________________	______________	___________
______________________________	______________	___________
______________________________	______________	___________

Family History:

	Age	Significant Health Problems		Age	Significant Health Problem
Father			Children		
Mother			☐M ☐F		
Siblings			☐M ☐F		
☐M ☐F			☐M ☐F		
☐M ☐F			Grandmother (paternal)		
☐M ☐F			Grandfather (paternal)		
☐M ☐F			Grandfather (maternal)		
☐M ☐F			Grandmother(maternal)		

Mental Health:

	YES	NO
1. Is Stress a Major Problem for You?	☐	☐
2. Do You Feel Depressed?	☐	☐
3. Do You Panic When Stressed?	☐	☐
4. Do You Have Problems With Eating or Your Appetite?	☐	☐
5. Do You Cry Frequently?	☐	☐
6. Have You Ever Attempted Suicide?	☐	☐
7. Have You Ever Seriously Thought About Hurting Yourself?	☐	☐
8. Do You Have Trouble Sleeping?	☐	☐
9. Have You Ever Been to a Counselor?	☐	☐

Men Only:

	YES	NO
1. Do You Usually Get Up to Urinate Through the Night? If Yes, How Many Times? ____	☐	☐
2. Do You feel Pain or Burning When Urinating?	☐	☐
3. Any Blood in Your Urine?	☐	☐
4. Do You Feel Burning Discharge From Penis?	☐	☐
5. Has the Force of your Urination Deceased?	☐	☐
6. Have You Had Any Kidney, Bladder or Prostate Infections within the last 12 Months?	☐	☐
7. Do You Have Any Problems Emptying Your Bladder Completely?	☐	☐
8. Any Difficulty with Erection or Ejaculation?	☐	☐
9. Any Testicle Pain or Swelling?	☐	☐
10. Date of Last Prostate Exam ____________ Rectal Exam ______________		

Women Only:

	YES	NO
1. Age at Onset of Menstruation ________		
2. Date of Last Menstruation ________ Period Every _____ Days		
4. Heavy Periods, Irregularity, Spotting, pain or Discharge	☐	☐
5. Number of Pregnancies _____ Number of Live Births _____		
6. Are You Pregnant or Nursing?	☐	☐
7. Have You Had a D&C, Hysterectomy or Cesarean?	☐	☐
8. Any Urinary tract, Bladder or Kidney Infections Within the Last Year?	☐	☐
9. Any Blood in Your Urine?	☐	☐
10. Any Problem With Control of Urination?	☐	☐
11. Any Hot Flashes or Sweating at Night?	☐	☐
12. Do You Have Menstrual Tension, Pain, Bloating, Irritability at the Time of Period?	☐	☐
13. Experienced Any Recent Breast Tenderness, Lumps or Nipple Discharge?	☐	☐
14. Date of Last Pap Exam ___________ Rectal Exam _____________	☐	☐

Other Conditions/Discomforts (please check and briefly explain any conditions/discomforts affecting the following)

☐ Skin____	☐ Bladder____
☐ Head/Neck__________________________________	☐ Chest / Heart ________________________________
☐ Ears ____	☐ Circulation ___________________________________
☐ Nose ____	Recent Changes in:
☐ Throat ______________________________________	☐ Weight _______________________________________
☐ Lungs _______________________________________	☐ Energy Level__________________________________
	☐ Ability to Sleep ______________________________

Is There Anything Else About Your Physical and/or Mental Health That you Feel Our Providers Should Know?

If Yes, Please Explain:____

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The Information Contained in This Medical History Form, is to the Best of my Reasonable Information and Belief, True Correct and Accurate

Signature of Patient:____________________________________ Date:___________________