RYKEN CHIROPRACTIC & WELLNESS CENTER
610 N. Alma School Rd Ste 50
Chandler, AZ 85224
(480) 857-1991

New Patient Registration and Accident Questionnaire

Name: _____ Age: _____Date of birth: _____ Date: _____
LAST FIRST MIDDLE

Address: _____Social Security #: _____ ☐ Male ☐ Female

City, State, Zip: _____Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone (_____)_____Work Phone (_____) _____

Cell Phone (_____) _____Email address: _____

Employer: _____ Spouse's Name: _____

Occupation: _____ Spouse's Employer: _____

In case of emergency, notify_____ Relationship: _____ Phone (_____) _____

Current Symptoms: 1._____ 2._____ 3._____ 4._____

5. _____ 6. _____ 7. _____ 8. _____

When did your symptoms begin? _____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

Where there any symptoms which you had after the crash that have now resolved? (please list)

_____

Please list all medications and dosage: **Frequency** **For What Illness?**

_____

_____

List any allergies to medications, foods or other: _____

Are you pregnant? ☐ Yes ☐ No First day of last menstrual cycle: _____

Do you smoke? ☐ Yes ☐ No; How much? _____ Do you drink alcohol? ☐ Yes ☐ No; How much? _____

Please list all serious illness and serious accidents: **Month and Year** **City, State**

_____

_____

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Patient's Name: _____ Date: _____

Please list any recent x-rays, lab or other tests: **Date** **Facility/Doctor**

_____

_____

Date of Crash: _____ Hour: _____AM _____PM _____

Specific Location of Crash: _____

Describe in detail, in your own words, how the crash/accident happened: _____

_____

_____

_____

AUTOMOBILE/MOTORCYLCE ONLY

In the crash: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? _____

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

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐Left Side ☐ Right Side

Were traffic citations issued to? ☐ You ☐ Driver of Your Vehicle ☐ Driver of the Other Vehicle ☐ No Citations Given

Was your vehicle heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

Was the other heading? ☐ North ☐ South ☐ East ☐ West on _____ (Street/Highway)

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE CRASH/ACCIDENT:

☐ Headache	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ Bruised Chest	☐ Radiating Pain	☐ *Dizziness*
☐ Sleeping Problems	☐ Bruising Anywhere	☐ Tingling in Legs	☐ Loss of Smell
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ Loss of Taste
☐ *Anxiety*	☐ Sensitivity to Light	☐ Jaw Pain	☐ *Any Burns*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Any Stitches*
☐ Muscle Spasms	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Any Cuts*

☐ Other Symptoms: _____

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates: _____ to _____

Where did you go after the crash? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other _____

Were you taken by ambulance? ☐ Yes ☐ No **To which hospital?** _____

Address: _____ Date of Hospitalization: _____

Attending E.R. Doctor: _____ Treatment Given? _____

Have you done any of the following since the crash:

☐ Ice	☐ Medication (name)_____	☐ Rest
☐ Heat (any kind)	☐ Exercise	☐ Other_____

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Patient's Name: _____ Date: _____

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

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address: _____Telephone: (_____) _____Insured: _____

Claim #: _____Policy #: _____

Claim Representative: _____

Telephone: (_____) _____ Fax: (_____) _____

Med-Pay Benefits: _____ Uninsured (UM) Benefits: _____ Underinsured (UIM) Benefits: _____

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured: _____

Date of Birth: _____Policy #: _____ SS#: _____

Telephone: (_____) _____ Fax: (_____) _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address: _____ Claims Rep: _____

Claim #: _____Policy #: _____Insured: _____

Telephone: (_____) _____ Fax: (_____) _____

4) ATTORNEY: _____Legal Assistant: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

HIPAA Compliance

Our office 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: _____

RYKEN CHIROPRACTIC & WELLNESS CENTER

Ryan Hicks DC.

Patient's Name: _____ Today's Date: _____

Auto Accident Mechanism of Injury Form

Date of Collision: _____ Hour of Accident: _____ AM / PM

Please describe how the collision happened: _____

_____

_____

_____

What was your position in the car? (Circle) **Driver** / **Front Passenger** / **Left Rear** / **Right Rear**

If "Driver", were your hands on the steering wheel? **Both** / **Left** / **Right**

Did the airbags deploy? **Yes** / **No**

Did you strike another vehicle? **Yes** / **No** Did another vehicle strike your vehicle? **Yes** / **No**

Angle of Impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

If Second Collision – Angle of 2nd impact: **Front** / **Back** / **Left** / **Right** / **Other**: _____

1) In relation to the back of your head, was your headrest set: **Low** / **Middle** / **High**

2) Were you surprised by the impact? **Yes** / **No**

If "NO", how did you brace? **With Hands** / **With Feet**

3a) Where was your head facing at the time of impact? **Straight Ahead** / **Left** / **Right** / **Behind**

3b) Were you leaning forward at the time of impact? **Yes** / **No**

4) What type and year of vehicle were you in? _____

_____

4a) What was the approximate speed of your vehicle when the accident occurred? _____ mph

5) What type and year of vehicle struck yours?_____

_____

5b) What was the approximate speed of the other vehicle when the accident occurred? _____ mph

6) Were you wearing a seatbelt? **Yes** / **No** What type: **Lap Belt** / **Shoulder Belt** / **Both**

7) Did you feel pain immediately after the accident? **Yes** / **No**

Were you rendered unconscious as a result of the accident? **Yes / No**

Did you strike anything in the vehicle at the time of impact? **Yes** / **No** If "YES", specify what part of your body struck what: (i.e. head, chest, chin, shoulder, knee, etc.)

□ Steering Wheel	□ Windshield
□ Dashboard	□ Roof
□ Left Side Door	□ Right Side Door
□ Left Window	□ Right Window
□ Other	

RYKEN CHIROPRACTIC & WELLNESS CENTER

Ryan Hicks DC.

Patient's Name: _____ Today's Date: _____

Did your seat break or bend? **Yes** / **No**

Immediately following the accident, how did you feel? (Circle all that apply) **Dizzy** / **Dazed** / **Weak** / **Upset** / **Disoriented** / **Nervous** / **Nauseous** / **Other**: _____

Police and Ambulance:

Was the accident reported to the police? **Yes** / **No**

Were traffic citations issued? **Yes** / **No** If "YES", to whom? _____

Did you go to the hospital? **Yes** / **No** If "YES", when? _____

If "YES", how did you get there? **Ambulance** / **Police Car** / **Private Transportation**

Were you admitted? **Yes** / **No** If "YES", how long? _____

Name of Hospital? _____ Attended by Dr. _____

What treatment given? (Circle all that apply) **None** / **X-rays** / **Pain Medication** / **Stitches** / **Muscle Relaxants** / **Bandaged** / **Cervical Collar** / **Physical Therapy** / **Instructed Regarding Concussion** / **Instructed Regarding Sprains & Strains** / **Instructed to Call an Orthopedist** / **Instructed to Call a Private Physician** / **Referred to This Office** / **Other**: _____

What other doctor have you seen as a result of this injury? _____

Do you have difficulty in excessive: **Standing** / **Walking** / **Riding** / **Bending** / **Twisting**

Do you have difficulty in excessive lifting: **Light** / **Moderate** / **Heavy** / **Repetitive**

Symptoms other than above: _____

_____ _____

Patient Signature Date

RYKEN CHIROPRACTIC & WELLNESS CENTER

Ryan Hicks DC.

Patient's Name: _____ Date: _____

Duties Under Duress Summary

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

Work	**Reason for the difficulty**	**Duration**
Job Description: _____		
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____

Studies/School	**Reason for the difficulty**	**Duration**
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

Domestic Duties	**Reason for the difficulty**	**Duration**
Vacuuming	Increased Pain	_____
Taking Care of Kids	Increased Anxiety	_____
Cleaning	Increased Pain	_____
Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	**Reason for the difficulty**	**Duration**
Yardwork	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____

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Ryan Hicks DC.

Patient's Name: _____ Date: _____

Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

Work	**Reason for the difficulty**	**Duration**
Job Description: _____		
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____

Studies/School	**Reason for the difficulty**	**Duration**
Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

RYKEN CHIROPRACTIC & WELLNESS CENTER

Ryan Hicks DC.

Patient's Name: _____ Date: _____

Loss of Enjoyment

Domestic Duties	Reason for the difficulty	Duration
Vacuuming	Increased Pain	_____
Taking Care of Kids	Increased Anxiety	_____
Cleaning	Increased Pain	_____
Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	Reason for the difficulty	Duration
Yardwork	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____

Sports	Reason for the difficulty	Duration
Social	_____	_____
Competitive	_____	_____
Regional	_____	_____
Other:	_____	_____

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QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

REVISED OSWESTRY BACK PAIN DISABILITY QUESTIONNAIRE

Name _____ Date _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE*** *which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just* ***mark the one box which most closely describes your problem right now.***

SECTION 1 – Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives me extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned-eg, on a table
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than 1 mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me sitting more than ½ hour.
E. Pain prevents me sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

OTHER COMMENTS:

_____

_____

SECTION 6 – Standing

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than 1 hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than 10 minutes without increasing pain.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping

A I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, eg, dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling

A. I get no pain while traveling.
B. I get some pain while traveling but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

_____
Examiner

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.