Patient Name: _____ **Date:** _____

IMPORTANT

If you have already retained an attorney for <u>this</u> case, please inform us prior to filling out this paperwork.

If, at any point during your care, you decide that you need an attorney, please discuss it with the doctor <u>prior</u> to retaining one.

Robbins Chiropractic PC Dr. Matthew D. Robbins

Patient Name: _____ **Date:** _____

Home Phone #: _____ Work Phone #: _____

Occupation:_____ Employer: _____

Emergency Contact Required: _____ Phone: _____ Relation: _____

Have you received any other treatment for your injuries from *this accident*? **NO** | **YES**

If YES, circle treatment(s) received:

Anti-inflammatory Meds	Pain Meds	Surgery	Other _____
Cortisone Injections	Massage	Trigger Point Injections	
Chiropractic	Muscle Relaxers	Physical Therapy	

Family History - Place an X in all applicable boxes

Condition	Mother	Father	Sibling	Grandmother		Grandfather		Notes
				Maternal	Paternal	Maternal	Paternal	
Cancer								
High Blood Pressure								
Heart Attack								
Diabetes								
Stroke								
Osteoarthritis								
Other								

Females: Are you pregnant? **Yes** **No** Due date_____

Past Health History:

Previous Injury/Trauma: _____

Have you ever broken any bones? Which? _____

Medications:

Medication + reason for taking

_____

Surgeries:

Surgery - exact date (best guess)

_____

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance is billed, I authorize payment of medical benefits to **Dr. Matthew Robbins** for services performed.

Patient or Guardian Signature _____ Date_____

1625 W. Ina Road Ste 117 Tucson, AZ 85704 Phone 520-690-1100 Fax 520-690-1137

Patient Name: _____ **Date:** _____

PERSONAL INJURY INFORMATION

FULL NAME_____ PHONE_____
ADDRESS_____ CITY_____ ST_____ ZIP___
_____AGE_____ BIRTH DATE_____ SEX **M F** SS#_____
DATE OF ACCIDENT_____TIME OF DAY_____AM/PM
EMERGENCY CONTACT_____PHONE #_____
ADDRESS_____ RELATIONSHIP_____

3rd party liability/Medpay will be billed first.
General health insurance will only be billed if the auto insurance is exhausted, denied or you request us to do so.

YOUR AUTO INSURANCE INFORMATION:

Name of Insured_____ Policy #_____
Insurance Company_____ Phone #_____
"Med Pay" Claim #_____ Adjuster/Phone#_____

THE AUTO INSURANCE OF THE OTHER PARTY INVOLVED:

Name of Insured_____ Policy #_____
Insurance Company_____ Phone #_____
Adjuster/Phone#_____ Claim #_____

YOUR HEALTH INSURANCE INFORMATION:

Name of Insured_____ Relationship to you_____
Insurance Company_____
Group Plan #_____ Phone #_____
Insured ID#_____
Please give us a copy of your ID card.

ATTORNEY INFORMATION (IF APPLICABLE):

Attorney Name_____ Phone #_____
Address_____ City_____ St_____ Zip_____

****IF YOU RETAIN AN ATTORNEY AT A LATER DATE, PLEASE NOTIFY US IMMEDIATELY****

PLEASE ALLOW US TO MAKE A COPY OF THE FOLLOWING:

DRIVER'S LICENSE OR PICTURE ID
HEALTH INSURANCE CARD
INCIDENT REPORT

Robbins Chiropractic PC
Dr. Matthew D. Robbins

Patient Name: _____ **Date:** _____

REVIEW OF SYSTEMS

ALLERGIES/IMMUNOLOGIC HISTORY

☐ **ALL NEVER**

Allergic Reactions	____Current	____Past	____Never
Anaphylaxis History	____Current	____Past	____Never
Angioedema History	____Current	____Past	____Never
Drug Allergies	____Current	____Past	____Never
Frequent Injections	____Current	____Past	____Never
Hay Fever	____Current	____Past	____Never
Hepatitis	____Current	____Past	____Never
HIV Positive	____Current	____Past	____Never
Positive Tuberculosis	____Current	____Past	____Never
Seasonal Allergies	____Current	____Past	____Never
COVID	____Current	____Past	____Never
Rheumatoid Arthritis	____Current	____Past	____Never
Psoriatic Arthritis	____Current	____Past	____Never
Osteoarthritis	____Current	____Past	____Never

Cardiovascular History

☐ **ALL NEVER**

Chest Pain	____Current	____Past	____Never
Heart Murmur	____Current	____Past	____Never
High Blood Pressure	____Current	____Past	____Never
Irregular Heart Beat	____Current	____Past	____Never
Swelling of Legs	____Current	____Past	____Never
Use of Oxygen	____Current	____Past	____Never
Varicose Veins	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Gastrointestinal History

☐ **ALL NEVER**

Abdominal Pain	____Current	____Past	____Never
Constipation	____Current	____Past	____Never
Diarrhea	____Current	____Past	____Never
Gluten Intolerance	____Current	____Past	____Never
Indigestion/Heartburn	____Current	____Past	____Never
Nausea	____Current	____Past	____Never
Crohn's Disease	____Current	____Past	____Never
Ulcerative Colitis	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Musculoskeletal History

☐ **ALL NEVER**

General Joint Pain	____Current	____Past	____Never
Walking/Balance Problems	____Current	____Past	____Never
Osteoporosis	____Current	____Past	____Never
Ehlers-Danlos Syndrome	____Current	____Past	____Never
Hypermobility	____Current	____Past	____Never
Osteopenia	____Current	____Past	____Never
Joint Replacement	____Current	____Past	____Never
Spinal Fusion	____Current	____Past	____Never
Disc Replacement	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Psychiatric History

☐ **ALL NEVER**

Depression	____Current	____Past	____Never
Memory/Forgetfulness	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Endocrinological History

☐ **ALL NEVER**

Diabetes Type I	____Current	____Past	____Never
Diabetes Type II	____Current	____Past	____Never
Hypoglycemia	____Current	____Past	____Never
Thyroid	____Current	____Past	____Never

Hematologic/Lymphatic History

☐ **ALL NEVER**

Anemia	____Current	____Past	____Never
Blood Clotting Problems	____Current	____Past	____Never
Easy Bruising/Bleeding	____Current	____Past	____Never
Enlarged Lymph Nodes	____Current	____Past	____Never
Swollen Glands	____Current	____Past	____Never
PVD	____Current	____Past	____Never
AbdominalAortic Aneurysm	____Current	____Past	____Never
Deep Vein Thrombosis	____Current	____Past	____Never
Cancer	____Current	____Past	____Never
Hemophilia	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Neurological History

☐ **ALL NEVER**

Dizzy Spells	____Current	____Past	____Never
Headaches	____Current	____Past	____Never
Loss of Balance	____Current	____Past	____Never
Migraines	____Current	____Past	____Never
Numbness/Tingling	____Current	____Past	____Never
Tremors	____Current	____Past	____Never
Ringing in Ears	____Current	____Past	____Never
Seizures	____Current	____Past	____Never
Slurred Speech	____Current	____Past	____Never
Stroke	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

Respiratory History

☐ **ALL NEVER**

Blood in Sputum	____Current	____Past	____Never
Frequent Cough	____Current	____Past	____Never
Shortness of Breath	____Current	____Past	____Never
Wheezing	____Current	____Past	____Never
Other_____	____Current	____Past	____Never

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