The Robbins Chiropractic Center **Motor Vehicle Collision Questionnaire** **Dr. Matthew D. Robbins**

Patient Name: _____ Date: _____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____
Social Security #_____
Occupation_____
Employer_____

1. 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	Muscle Relaxers
Trigger Point Injections	Cortisone Injections	Massage
Physical Therapy	Chiropractic	Other_____

2. Since the Motor Vehicle Collision, have you experienced any of the following:

A. Loss of Range of Motion: yes/no
   a. What body part(s):_____
B. Visual Disturbance: yes/no (please explain):_____
C. Dizziness: yes/no How often: _____
D. Anxiety: yes/no How often: _____
E. Depression: yes/no How often: _____
F. Difficulty Sleeping: yes/no How often: _____

3. Past Health History:

A. Previous illnesses you've had in your life:
_____

B. Previous Injury or Trauma:
_____

Have you ever broken any bones? Which?
_____

C. Allergies: _____

D. Medications:

Medication Reason for taking
_____
_____
_____
_____

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

Patient Name: _____ Date: _____

E. Surgeries:

Date Type of Surgery

_____ _____
_____
_____ _____
_____

F. Females/ Pregnancies and outcomes:

Pregnancies and delivery dates *(live birth/still birth/misc/term)*

_____ _____
_____
_____ _____
_____

4. Family Health History:

Associated health problems of relatives:

_____
_____
_____

Deaths *due to illness* in immediate family: Age at death

_____ _____
_____
_____

5. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

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 will be billed, I authorize payment of medical benefits to **Dr. Matthew Robbins** for services performed.

Patient or Guardian Signature _____Date_____

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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_____

YOUR INSURANCE INFORMATION:

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

THE 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_____

PLEASE ALLOW US TO MAKE A COPY OF THE FOLLOWING:

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

Patient Name: _ __ ___ ___ Date: __ ___ ___

REVIEW OF SYSTEMS

Have you ever been diagnosed with any Pulmonary (Lung) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Asthma/difficulty breathing ☐ COPD ☐ Emphysema ☐ Other_____

Have you ever been diagnosed with any Cardiovascular (Heart) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Heart surgeries ☐ Congestive heart failure ☐ Murmurs or valvular disease
☐ Heart attacks ☐ Heart disease/problems ☐ hypertension
☐ Pacemaker ☐ Angina/chest pain ☐ Irregular heartbeat
☐ Other_____

Have you ever been diagnosed with any Neurological (Nerve) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Visual changes/loss of vision ☐ One-sided weakness of face or body
☐ History of seizures ☐ 1-sided decreased feeling in face or body
☐ Headaches ☐ Memory loss
☐ Tremors ☐ Vertigo
☐ Loss of sense of smell ☐ Strokes/TIAs
☐ Other_____

Have you ever been diagnosed with any Endocrine (Gland) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Thyroid disease ☐ Hormone replacement therapy ☐ Injectable steroid replacements

Have you ever been diagnosed with any Renal (Kidney) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Renal calculi/stones ☐ Hematuria ☐ Incontinence ☐ Bladder infections
☐ Difficulty urinating ☐ Kidney disease ☐ Dialysis ☐ Other_____

Have you ever been diagnosed with any Gastroenterological (Intestinal) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Nausea ☐ Difficulty swallowing
☐ Ulcerative disease ☐ Frequent abdominal pain
☐ Hiatal hernia ☐ Constipation
☐ Pancreatic disease ☐ Irritable bowel/colitis
☐ Hepatitis or liver disease ☐ Bloody or black tarry stools
☐ Vomiting blood ☐ Bowel incontinence
☐ Gastroesophageal reflux/heartburn ☐ Other_____

Have you ever been diagnosed with any Hematological (Blood) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Anemia ☐ Regular anti-inflammatory use
☐ HIV positive ☐ Abnormal bleeding/bruising
☐ Sickle-cell anemia ☐ Enlarged lymph nodes
☐ Hemophilia ☐ Hypercoagulation/deep vein thrombosis
☐ Anticoagulant therapy ☐ Regular aspirin use
☐ Other_____

Have you ever been diagnosed with any Dermatological (Skin) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Significant burns ☐ Significant rashes ☐ Skin grafts ☐ Psoriatic disorders ☐ Other_____

Have you ever been diagnosed with any Musculoskeletal (Bone) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Rheumatoid Arthritis ☐ Gout ☐ Osteoarthritis ☐ Broken bones
☐ Spinal fracture ☐ Spinal surgery ☐ Joint surgery ☐ Arthritis (unknown type)
☐ Scoliosis ☐ Metal implants ☐ Other_____

Have you ever been diagnosed with any Psychological (mental) Disorders ☐ **No** ☐ **Yes** (check below)
☐ Psychiatric diagnosis ☐ Depression ☐ Suicidal ideations
☐ Bipolar Disorder ☐ Homicidal ideations ☐ Schizophrenia
☐ Psychiatric hospitalizations ☐ Other_____