

**CARRION CHIROPRACTIC CLINIC/CRAIG T. CARRION, D.C.**  
4500 East Speedway, Suite 77, Tucson, AZ 85712  
PHONE (520) 319-1234 FAX (520)319-6543  
craigcarrion@hotmail.com

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 (\_\_\_\_) \_\_\_\_\_

Chief Complaint or Reason for Office Visit: \_\_\_\_\_

Specific Date and Time of Onset of Symptoms: \_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_ What makes your symptoms worse? \_\_\_\_\_

What is the quality of your symptoms? (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

<u>Please list all medications and dosage:</u>	<u>Frequency</u>	<u>For What Illness?</u>
_____	_____	_____
_____	_____	_____

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? \_\_\_\_\_

<u>Please list all serious illness and serious accidents:</u>	<u>Month and Year</u>	<u>City, State</u>
_____	_____	_____
_____	_____	_____

<u>Please list any recent x-rays, lab or other tests:</u>	<u>Date</u>	<u>Facility/Doctor</u>
_____	_____	_____
_____	_____	_____

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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Hour: \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_

Specific Location of Accident: \_\_\_\_\_

Describe in detail, in your own words, how the accident happened: \_\_\_\_\_

In the accident: Were you the  Driver  Passenger  Pedestrian  Other? \_\_\_\_\_

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

Were you struck from:  Behind  Front  Side Impact  Driver's Side  Passenger's Side

Were traffic citations issued to:  You  the Driver of Your Car  the Driver of the Other Car  No Citations Given

Was your car 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 ACCIDENT:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Middle Back Pain     | <input type="checkbox"/> Lower Back Pain      | <input type="checkbox"/> Ears Ring       |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Lower Back Stiffness | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Neck Stiffness    | <input type="checkbox"/> Bruised Chest        | <input type="checkbox"/> Radiating Pain       | <input type="checkbox"/> Dizziness       |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Bruising Anywhere    | <input type="checkbox"/> Tingling in Legs     | <input type="checkbox"/> Loss of Smell   |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Blurred Vision       | <input type="checkbox"/> Tingling in Arms     | <input type="checkbox"/> Loss of Taste   |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> Any Burns       |
| <input type="checkbox"/> Fainting          | <input type="checkbox"/> Upper Arm Pain       | <input type="checkbox"/> Upper Leg Pain       | <input type="checkbox"/> Any Stitches    |
| <input type="checkbox"/> Muscle Spasms     | <input type="checkbox"/> Lower Arm Pain       | <input type="checkbox"/> Lower Leg Pain       | <input type="checkbox"/> Any Cuts        |

Other Symptoms: \_\_\_\_\_

Have you lost time from work?  Yes  No: If Yes, Dates: \_\_\_\_\_ to \_\_\_\_\_

Where did you go after the accident?  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? \_\_\_\_\_

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

- |   |  |  |   |
|---|--|--|---|
| Tuberculosis <input type="checkbox"/> Yes   | Lung Disease <input type="checkbox"/> Yes    | Gout <input type="checkbox"/> Yes            | Diabetes <input type="checkbox"/> Yes   |
| Kidney Disease <input type="checkbox"/> Yes | Stomach/Ulcer <input type="checkbox"/> Yes   | Heart Disease <input type="checkbox"/> Yes   | Hepatitis <input type="checkbox"/> Yes  |
| Sciatica <input type="checkbox"/> Yes       | Blood Pressure <input type="checkbox"/> Yes  | Transfusion <input type="checkbox"/> Yes     | Polio / MS <input type="checkbox"/> Yes |
| Colon Disease <input type="checkbox"/> Yes  | Stroke <input type="checkbox"/> Yes          | Cancer <input type="checkbox"/> Yes          | Bleeding <input type="checkbox"/> Yes   |
| Paralysis <input type="checkbox"/> Yes      | Seizures <input type="checkbox"/> Yes        | Arthritis <input type="checkbox"/> Yes       | Asthma <input type="checkbox"/> Yes     |
| Anemia <input type="checkbox"/> Yes         | Thyroid Disease <input type="checkbox"/> Yes | Drug Dependence <input type="checkbox"/> Yes | AIDS <input type="checkbox"/> Yes       |

**CARRION CHIROPRACTIC CLINIC**

**Craig T. Carrion, D.C.**

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**Attorney/ Law Firm:**

Name of Attorney/Law firm:

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Attorney or case manager email:

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**HIPAA Compliance**

Carrion Chiropractic 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. The signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature:

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Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Initials: \_\_\_\_\_

**Acknowledgement and Agreement:  
Patient's Protocol for Records Preservation**

I, \_\_\_\_\_, patient of Dr. Carrion, do hereby acknowledge I have read and understand the doctor's protocol for the preservation of patient records. I agree to inform Dr. Carrion's office of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to my indicated address, which is on file at this office.

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

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## INFORMED CONSENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

As a patient in my office, you have the legal right to know of the type of treatment we will use, any complications/side-effects, as well as alternatives to chiropractic care and their complications. This form is intended to inform you of these, and treatment cannot be given until you understand these issues and sign this form. If you have any questions after reading this form, please ask me or my staff members.

The primary treatment used by Doctor of Chiropractic is the spinal adjustment to reduce spinal subluxations (slight dislocations or misalignments of the spinal joints). I will use that procedure to treat you as well as other common secondary treatments such as physical therapies and modalities.

- The nature of the chiropractic adjustment: I will use my hands upon your spine in such a way as to move your spinal joints to restore normal joint play. This procedure may cause an audible “pop” or “click” similar to what you feel when you pop your knuckles. You may feel or sense movement of the joint, and this usually gives you a very pleasant sense of relief. If a traditional spinal adjustment is inappropriate for your condition, there are other non-forceful types of spinal adjustments that may be used. If, from previous experiences, you prefer non-traditional types of spinal adjustments, please inform the staff beforehand.
- The material risk inherent in a chiropractic adjustment: While serious complications occur only 1-2 times per million adjustments, there is a slight risk, such as fractures, disc injuries, dislocations, muscle strains, Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some patients will feel some stiffness or soreness following the first few days of treatment, which is considered normal.
- The probability of those risks occurring:
  - Fractures, especially of the ribs, are rare occurrences and generally results from some underlying weaknesses of the bone such as osteoporosis. If you suffer from osteoporosis, we will make special efforts to adjust your spine carefully.
  - Stroke has been the subject of tremendous disagreement within the health professions. Usually there is an underlying, pre-existing vascular condition like atherosclerosis that contributes to a stroke resulting after a neck adjustment. Some types of manipulation of the neck have been associated with other injuries to the arteries in the neck leading to a stroke in rare instances along the lines of 1 per 3 million. Mortality from spinal adjustments is 3 per 10 million.
  - Disc injuries are frequently successfully treated by chiropractic adjustments, yet occasionally chiropractic treatment may aggravate the problem, and rarely surgery may become necessary if symptoms are not improved within 4 weeks. If need be, we will refer you to a neurosurgeon or for an MRI exam. These problems occur so rarely that there are no available statistics to quantify their probability.
- Ancillary treatments: In addition to chiropractic adjustments, I intend to use the following treatments if necessary to control your pain or to stabilize your spinal weakness:
  - Ice or hot packs: We may use both heat and ice packs and recommend ice for home use. Both may irritate or burn your skin if overused for more than 20-30 minutes without a layer of clothing between your skin and the ice/heat pack. The results are temporary and occur so rarely that there are no available statistics to quantify their probability.
  - Electro-therapy: This modality consists of a mild electrical current which sends a massage-type action through the muscles and nerves to relax constricted muscles, to block pain impulses, to reduce swelling and to facilitate healing in muscles and ligaments. There are no known side effects.

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- **Alternative Medical Treatments & Risks:** Other treatments are available for your condition include:
  - Self-administered over the counter, NSAIDs may cause gastrointestinal problems in 1,000 to 4,000 people per 1 million, and reportedly 16,500 people die annually from their use.
  - Prescription of muscle relaxants and pain killers can produce undesirable side effects and dependence. They can also make you quite drowsy and impair your motor skills.
  - Hospitalization and bed rest bear the additional risk of exposure to communicable disease, loss of muscle tone and strength at the rate of 4% a day. It is also extremely expensive, and research has shown bed rest had no benefit in helping back pain patients, in fact, it may contribute to worsening conditions.
  - Back and Neck Surgery have many risks: Infections; allergic reactions; disfiguring scar; severe loss of blood; loss of function or any limb or organ paralysis; paraplegia or quadriplegia; brain damage; cardiac arrest; death; loss of bladder, bowel, or sexual function; increased or continued pain or numbness; injury to vessels in the abdomen; post operative bleeding; injury to esophagus, trachea or lungs; hoarseness; spinal fluid leak; unstable spine requiring fusion; injury to GI or GU tract; recurrence of disc problems or scar tissue formation with progressive weakness or numbness; paralysis. In addition, other risks associated with anesthesia are loss of teeth; corneal abrasions; or abdominal reactions to anesthetic agents. Serious neurological complications from neck surgery are, per million; mortality rates are 6,900 per million.
- **The Risks and Dangers to Remaining Untreated:**
  - Remaining untreated allows the formation of adhesions and reduces joint motion, which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed. Disc degeneration, joint arthritis, nerve damage, muscular weakness and/or an increase or spinal distortion may progress if your spinal problem goes untreated.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. IF YOU HAVE UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK AND SIG BELOW.**

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic care and related treatments. I have discussed it with the doctor and/or staff of this office and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the health plan recommended. Having been informed of the nature and risks of chiropractic care, I hereby give my consent to be treated.

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

Signature: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

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**INITIAL DOCTOR-NEW PATIENT INTERVIEW FORM**

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Time In: \_\_\_\_\_ Time Out: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Doctor: \_\_\_\_\_ Date Of Exam: \_\_\_\_\_

Sex:  M  F Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_ # of Children: \_\_\_\_\_

Occupation: \_\_\_\_\_ Years: \_\_\_\_\_ Employer: \_\_\_\_\_

Are you or have you missed time from work?  Yes  No Type of Work:  Office  Clerical  Light  Moderate  Heavy Labor

Describe the type of work performed: \_\_\_\_\_

Were you on-the-job when the accident occurred?  Yes  No

Were you the:  Driver  Front Seat Passenger  Rear Seat Passenger  Motorcycle Operator  Motorcycle Passenger  Other

Vehicle was driven by: \_\_\_\_\_

Did your vehicle strike another vehicle?  Yes  No Did another vehicle strike your vehicle?  Yes  No

Were you struck from:  Behind  Front  Driver's side  Passenger's side  other \_\_\_\_\_

Were traffic citations issued? To whom?  You  Driver of your vehicle  Driver of other vehicle  None

Were police at the scene?  Yes  No If yes, was a report made?  Yes  No Did accident occur on  public or  private property

Your vehicle was heading:  North  South  East  West on \_\_\_\_\_ (Street/highway)

The other car heading:  North  South  East  West on \_\_\_\_\_ (Street/highway)

Your Vehicle (Year, Make, Model): \_\_\_\_\_

Your speed at the moment of accident:  Full Stop  Slowing  Accelerating  Legal Limit

The other Vehicle (Year, Make, Model) \_\_\_\_\_

Time of day:  Daylight  Dawn  Dusk  Dark Road conditions:  Dry  Damp  Wet  Snow  Ice  Other \_\_\_\_\_

Head restraints:  None  Integral Type  Adjustable:  Up  Down  Don't know

If adjustable, was the position altered by the accident?  Yes  No

Was the seat back adjustment altered by the accident?  Yes  No

Type of Restraints: \_\_\_\_\_

Did air bag deploy?  Yes  No If Yes, were you struck by airbag?  Yes  No Were you burned?  Yes  No

Body position: \_\_\_\_\_ Head position:  Forward  Left \_\_\_\_\_°  Right \_\_\_\_\_°  Up \_\_\_\_\_°  Down \_\_\_\_\_°

Position of Hands:  One on steering wheel  Two on steering wheel  N/A Were brakes applied at impact?  Yes  No

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Patient: \_\_\_\_\_

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Accident Description: (How did the accident happen?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you aware of impending crash:  Yes  No

Did your body hit any part of your vehicle?  Yes  No If yes, describe \_\_\_\_\_

Did anything inside the vehicle strike you?  Yes  No If yes, describe \_\_\_\_\_

Did your vehicle hit any other object after the crash?  Yes  No If yes, describe \_\_\_\_\_

Were you wearing a hat or eye glasses?  Yes  No If yes, were they still on after crash?  Yes  No

Did you lose consciousness?  Yes  No If yes, for how long \_\_\_\_\_

Estimated damage to your vehicle:  None  Minimal  Moderate  Major

Estimated damage to other vehicle:  None  Minimal  Moderate  Major

Since the crash, tell me ALL symptoms or injuries you have experienced and specifically when each began: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where did you go after accident?  Hospital  Urgent Care  Family Provider  Home  Work  Other \_\_\_\_\_

**Emergency Room Treatment:**

Were you seen in the ER:  Yes  No Which hospital: \_\_\_\_\_ Were taken by ambulance?  Yes  No

Date seen if not taken by ambulance \_\_\_\_\_

Was treatment given?  Yes  No If yes, X-rays:  Yes  No If yes, which body parts x-rayed \_\_\_\_\_

Results of X-rays: \_\_\_\_\_ Lab work:  Yes  No Results: \_\_\_\_\_

Cervical collar  Yes  No Ice  Yes  No Medication:  Yes  No If yes, name of Rx: \_\_\_\_\_

Other treatment: \_\_\_\_\_ Follow-up instructions: \_\_\_\_\_  None

Work restriction  Yes  No If yes, describe \_\_\_\_\_

**Other Treatment Since Accident #1:**

Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_ Treatment type: \_\_\_\_\_ Treatment frequency: \_\_\_\_\_

Treatment duration: \_\_\_\_\_ Currently treating?  Yes  No

Work restriction  Yes  No If yes, describe \_\_\_\_\_

Special tests: \_\_\_\_\_ Referred to: \_\_\_\_\_

Did treatment help?  Yes  No Comments: \_\_\_\_\_  
\_\_\_\_\_

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**Other Treatment Since Accident #2:**

Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_ Date first seen: \_\_\_\_\_

Referred by: \_\_\_\_\_ Treatment type: \_\_\_\_\_ Treatment frequency: \_\_\_\_\_

Treatment duration: \_\_\_\_\_ Currently treating?  Yes  No

Work restriction  Yes  No If yes, describe \_\_\_\_\_

Special tests: \_\_\_\_\_ Referred to: \_\_\_\_\_

Did treatment help?  Yes  No Comments: \_\_\_\_\_

<u>Chief Complaint 1</u>	<u>Chief Complaint 2</u>
Onset	Onset
Pain Scale (1 to 10)	Pain Scale (1 to 10)
Provocative	Provocative
Palliative	Palliative
Quality	Quality
Radiation	Radiation
Site (Location)	Site (Location)
Time (Frequency)	Time (Frequency)
<i>Frequency: &lt;25% Intermittent, 26-50% Occasional, 51-75% Frequent, &gt; 76% Constant</i>	

<u>Chief Complaint 3</u>	<u>Chief Complaint 4</u>
Onset	Onset
Pain Scale (1 to 10)	Pain Scale (1 to 10)
Provocative	Provocative
Palliative	Palliative
Quality	Quality
Radiation	Radiation
Site (Location)	Site (Location)
Time (Frequency)	Time (Frequency)
<i>Frequency: &lt;25% Intermittent, 26-50% Occasional, 51-75% Frequent, &gt; 76% Constant</i>	

<u>Chief Complaint 5</u>	<u>Chief Complaint 6</u>
Onset	Onset
Pain Scale (1 to 10)	Pain Scale (1 to 10)
Provocative	Provocative
Palliative	Palliative
Quality	Quality
Radiation	Radiation
Site (Location)	Site (Location)
Time (Frequency)	Time (Frequency)
<i>Frequency: &lt;25% Intermittent, 26-50% Occasional, 51-75% Frequent, &gt; 76% Constant</i>	

Treatment by Another Chiropractor: \_\_\_\_\_ Dates: \_\_\_\_\_