Bronson Chiropractic Office
4405 S Noland Rd, Ste A
Independence, MO 64055

Dr. Tim O Bronson
Ph: 816-373-7727

Motor Vehicle Collision Questionnaire

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_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
.
Name of most recent Chiropractor: _____

1. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**
   _____
   _____
   _____
   _____

2. **Since the Motor Vehicle Collision, have you experienced any of the following:**
   A. Loss of Range of Motion: yes/no
      a. What body parts: _____
   B. Visual Disturbance : yes/no □ blurring l/r □ floaters l/r □ vision loss l/r □ hypersensitivity l/r

      % of time: ___ % of time: ___ % of time: ___ % of time: ___

   C. Dizziness: yes/no % of time: ____
   D. Anxiety: yes/no % of time: ____
   E. Depression: yes/no % of time: ____
   F. Difficulty Sleeping: yes/no

3. **Past Health History:**

   A. Please indicate if you have a history of any of the following:
   □ Anticoagulant use □ Heart problems/high blood pressure/chest pain □ Bleeding problems
   □ Lung problems/shortness of breath □ Cancer □ Diabetes □ Psychiatric disorders
   □ Bipolar disorder □ Major depression □ Schizophrenia □ Stroke/TIA's □ Other _____
   □ None of the above

   B. Previous Injury or Trauma:
   _____
   _____

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Have you ever broken any bones? Which?
_____
_____

C. Allergies:
_____

D. Medications:

Medication Reason for taking
_____
_____
_____
_____
_____

E. Surgeries:

Date Type of Surgery
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)
□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes
□ Other _____ □ None of the above

Deaths in immediate family:
_____

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Cause of parents or sibling's death 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):
_____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney Disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation

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□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?
_____

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 **[name of doctor/clinic]** for services performed.

Patient or Guardian Signature _____

Date_____

NEW PATIENT HISTORY FORM

Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.

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Patient Name: _____ Date: _____

Symptom 1 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (Circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (Circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (Circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
      Other (please describe): _____
- Does the symptom radiate to another part of your body (Circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

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Patient Name: _____ Date: _____

Symptom 2 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)

    - **Did you have this symptom before this motor vehicle collision?** Yes/No

        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____

- What makes the symptom worse? (circle all that apply):

    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- What makes the symptom better? (circle all that apply):

    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

- Describe the quality of the symptom (circle all that apply):

    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
      Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no

    - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (circle one)

    - Morning Afternoon Evening Night Unaffected by time of day

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Patient Name: _____ Date: _____

Symptom 3 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? _____
    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)
    - **Did you have this symptom before this motor vehicle collision?** Yes/No
        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____
- What makes the symptom worse? (circle all that apply):
    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____
- What makes the symptom better? (circle all that apply):
    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____
- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
      Other (please describe): _____
- Does the symptom radiate to another part of your body (circle one): yes no
    - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one)
    - Morning Afternoon Evening Night Unaffected by time of day

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Patient Name: _____ Date: _____

Symptom 4 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)

    - **Did you have this symptom before this motor vehicle collision?** Yes/No

        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____

- What makes the symptom worse? (circle all that apply):

    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- What makes the symptom better? (circle all that apply):

    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

- Describe the quality of the symptom (circle all that apply):

    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
      Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no

    - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (circle one)

    - Morning Afternoon Evening Night Unaffected by time of day

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Patient Name: _____ Date: _____

Symptom 5 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)

    - **Did you have this symptom before this motor vehicle collision?** Yes/No

        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____

- What makes the symptom worse? (circle all that apply):

    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- What makes the symptom better? (circle all that apply):

    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

- Describe the quality of the symptom (circle all that apply):

    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
      Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no

    - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (circle one)

    - Morning Afternoon Evening Night Unaffected by time of day

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Patient Name: _____ Date: _____

Symptom 6 _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

    - Was this symptom a result of a motor vehicle collision? Yes/No (circle one)

    - **Did you have this symptom before this motor vehicle collision?** Yes/No

        - If so, what was the intensity (1-10 w/10 the worst) and frequency? ____

- What makes the symptom worse? (circle all that apply):

    - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- What makes the symptom better? (circle all that apply):

    - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): _____

- Describe the quality of the symptom (circle all that apply):

    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging,
      Other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no

    - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (circle one)

    - Morning Afternoon Evening Night Unaffected by time of day

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Dr Tim O Bronson
Ph: (816) 373-7727

Patient Name: _____Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issue, communicable diseases, health oversight, abuse or neglect, food or drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosure under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name