

CONFIDENTIAL PATIENT HISTORY

Auto Accident

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you.

Date: _____ E-mail Address: _____

Name: _____ Social Security # _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Age: _____ Date of Birth: _____

Children: _____ Marital Status: M S W D Occupation: _____

Spouse's Name: _____ Spouse's Office Phone: _____

Referred by: _____ Nearest Relative & Phone: _____

HEALTH INFORMATION: Have you had previous chiropractic care? _____

Reason for today's visit: Emergency New Injury Chronic Pain Wellness Visit

Are you in pain: Yes No Rate your pain with the following scale

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

What is your major complaint? _____

Other complaints: _____

Has this or something similar happened in the past? Yes No If yes, please explain: _____

Onset of complaints/condition/accident/injury, etc: _____

How long have you had this condition? _____ Have you had this or similar conditions in the past? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Constant Comes and go

Is this condition interfering with your: Work Sleep Daily Routine Other: _____

Other doctors who have treated this condition: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers "Pep" pills
 Insulin Others: _____

Do you take Supplements or Vitamins? No Yes

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | |
|--------------------------------------|-------------------------|-----------------------------|
| Y N Heart Attack | Y N Stroke | Y N Heart Surgery |
| Y N Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect |
| Y N Mitral Valve Prolapse | Y N Artificial Valves | Y N Alcohol Abuse |
| Y N Drug Abuse | Y N Venereal Disease | Y N Hepatitis |
| Y N Anemia | Y N Diabetes | Y N Shingles |
| Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma |
| Y N Kidney Problems | Y N High Blood Pressure | Y N Low Blood Pressure |
| Y N Psychiatric problems | Y N Rheumatic Fever | Y N Severe Headaches |
| Y N Frequent Headaches | Y N Tuberculosis | Y N Ulcers |
| Y N Colitis | Y N Fainting | Y N Seizures |
| Y N Epilepsy | Y N Sinus problems | Y N Emphysema |
| Y N Asthma | Y N Arthritis | Y N Difficulty Breathing |
| Y N Chemotherapy | Y N Lower back problems | |
| Y N Artificial Bones/Joints/Implants | | |

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above: _____

List any past serious accidents with dates: _____

Please list anything that you may be allergic to: _____

Family Health History: _____

Do you exercise? No Yes _____ hours per week

Do you smoke? No Yes How much? _____ How long? _____

Are you wearing: Shoe lifts Inner soles Arch supports

Are you dieting: No Yes Since ___/___/___

For Women: Are you taking birth control? No Yes

Are you nursing? Yes No Are you pregnant? No Yes How many weeks? _____

Auto Accident Information

Date and time of accident: _____

Were you the: Driver Front Passenger Rear Passenger

Make and model of the vehicle you were occupying: _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? Yes No

Was a police report filed? Yes No Were there any witnesses? Yes No

Were you wearing a seat belt? Yes No

Was this vehicle equipped with airbags? Yes No Did they inflate? Yes No

In relation to the base of your skull, where was the headrest? Above Below Base

What did your vehicle impact? Another vehicle Other If other, explain: _____

Did any part of your body strike anything in the vehicle? Yes No If yes, explain: _____

Name of the location/street on which you were traveling? _____

In which direction were you heading? N S E W

What was the approximate speed of your vehicle? _____

Did the impact to your vehicle come from the: Front Rear Right side Left side

During impact, were you facing: Right Left Forward

Were you aware of or surprised by the impact?

If accident vehicle made impact with other vehicle.... Direction other vehicle was headed? N S
 E W

Approximate speed of the other vehicle? _____

In your words, please describe the accident: _____

After Injury

Did the accident render you unconscious? Yes No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other doctor? Yes No

When did you go? Just after accident The next day 2 days plus

How did you get there? Ambulance Private transportation

Name of hospital and attending doctor: _____

Describe any treatment you received: _____

Were X-rays taken? Yes No Was medication prescribed? Yes No

Have you been able to work since this injury? Yes No

Are your work activities restricted as a result of this injury? Yes No

Indicate the symptoms that are a result of this accident:

- | | | | |
|---|--|---|-------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Irritability | <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numb hands/fingers | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Numb feet/toes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Stomach upset | |
| <input type="checkbox"/> Other: _____ | | | |

Is your condition getting worse? Yes No Constant Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lovemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney? Yes No If yes, whom? _____

His/Her phone #: _____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

- Standing Driving Operating equip. Sitting Twisting
 Walking Crawling Lifting Bending Typing
 Stooping Work with arms above head Other: _____

What positions can you work in with minimum physical effort and for how long?

Prior to the injury were you capable of working on an equal basis with others your age? Yes No
 N/A

Do you work with others who can help you with any heavy lifting? Yes No N/A

While in recovery, is there any light work you could request? Yes No N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Payment is due at the time services are rendered. Cash, check, or credit cards are acceptable forms of payment.
- For all HMO/PPO insurance groups that we are contracted with, co-pays, co-insurance, deductibles, and non-covered services are due at the time services are rendered. If an overpayment results based on an explanation of benefits, refunds will be issued. Any balance which is determined to be the patient responsibility on the explanation of benefits will be due immediately.
- For all insurance groups that we are not under contract with, assignment acceptance will be determined at the time the benefits are verified. If assignment is accepted, all co-pays, co-insurance, deductibles and non covered services will be due at the time the service is rendered. If we do not accept assignment, payment is due at the time services are rendered.
- For all discount plans that we participate in, payment is due at the time services are rendered.
- Auto accidents- appointments can only be scheduled if the accident has been reported to the responsible insurance companies. Our office staff will verify benefits. Any failure to comply with insurance guidelines, on the part of the patient, and denied claims are the result, they will be the patients financial responsibility.
- We allow a reasonable amount of time for claim processing. If claims are not processed within the state mandated time allowance, the account balance will be the patient's financial responsibility.
- Any and all account balances which are 90 days overdue will be sent to collections, and a surcharge will be applied to the account balance.
- Personal and business checks that are returned from the bank will incur a \$25 check return charge and will no longer be a valid form of payment.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits either to myself or to the party who accepts assignment.

- I authorize payments of medical benefits to David L. Frerking, D.C., D.A.B.C.I.
 - I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

DISCLOSURE & CONSENT FOR CHIROPRACTIC ADJUSTMENT AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:

 print name

 signature of patient

 date signed

To be completed by the patients' representative, if Necessary, e.g, if the patient is a minor or Physically or legally incapacitated:

 print name of patient

 print name of patient's representative

 signature of patient's representative

as: _____
 relationship or authority of patient's representative

 date signed

To be completed by doctor or staff

 witness to patient's signature

 date

 translated by

 date