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:____________________________________

Date and time of accident:____

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

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

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:

□ Dizziness	□ Difficulty Sleeping	□ Jaw problems	□ Nausea
□ Memory loss	□ Irritability	□ Arm/shoulder pain	□ Back pain
□ Headache(s)	□ Fatigue	□ Numb hands/fingers	□ Tension
□ Blurred vision	□ Back stiffness	□ Buzzing in ear	□ Neck pain
□ Chest pain	□ Leg pain	□ Ears ringing	□ Neck stiff
□ Nemb feet/toes	□ Shortness of breath	□ Stomach upset	

□ 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	□	□	□
Lying on side	□	□	□
Lying on stomach	□	□	□
Sitting	□	□	□
Standing	□	□	□
Stretching	□	□	□
Lovemaking	□	□	□
Walking	□	□	□
Running	□	□	□
Reaching	□	□	□
Working	□	□	□
Lifting	□	□	□
Bending	□	□	□
Kneeling	□	□	□
Pulling	□	□	□

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.

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:	To be completed by the patients' representative, if Necessary, e.g, if the patient is a minor or Physically or legally incapacitated:
______________________ print name	________________________ print name of patient
______________________ signature of patient	________________________ print name of patient's representative
______________________ date signed	________________________ signature of patient's representative
representative	as:___________________________ relationship or authority of patient's
	________________________ date signed

To be completed by doctor or staff

______________________	____________	___________________________	____________
witness to patient's signature	date	translated by	date