MONTROSE FAMILY
CHIROPRACTIC
763-675-3121

We would like to take a moment to welcome you to our office and thank you for choosing our facility for your chiropractic health care.

It has been our privilege to have helped many patients who suffer with similar health problems. We recognize that each patient is different, each with their own individual problems, requiring individual attention to their needs. If at any time you have a question, or concerns, please feel free to contact our clinic immediately at **(763) 675-3121.**

To help with your care, the following are some basic suggestions. The doctor will also give more specific instructions as needed.

Muscle Strain:

If you over-stretch a muscle, or work it too hard, you will strain it. Muscles are made up of thousands of tiny fibers. When you strain a muscle a few of these fibers will break. Your muscle will start to feel better when these fibers begin to heal. This will happen over the next few weeks.

Immediately upon injury, ice pack the strained area to fight the swelling. Follow the directions below. Rest is important as well, especially during the next few days. After that you will begin to gently stretch the muscles. This will help them to start to work normally again. Don't use the muscle so much that it hurts. Avoid full strength use of the muscle until it is totally pain free. ***Call Your Chiropractor*****,** if the pain is getting worse or any new symptoms are noticed.

Many people experience increased pain the following day after the initial visit. This is common.

*** If the pain is sharp or stabbing, ice is recommended for **TEN** minutes at a time. Repeat as needed after waiting an hour each time.

*** If the pain is an achy feeling, like you feel after exercising for a longer time than usual, heat is recommended for **TEN** minutes at a time. Wait an hour and repeat as necessary.

Immediately after your treatment it is not recommended that vigorous activities be performed.

If you have problems that we have not discussed, ***CALL OR VISIT YOUR CHIROPRACTOR RIGHT AWAY.***

Montrose Family Chiropractic Clinic
PO Box 406
Montrose, MN 55363

Auto Accident Information

Patient's Name: ______________________________ **Today's Date:** ___/___/_____

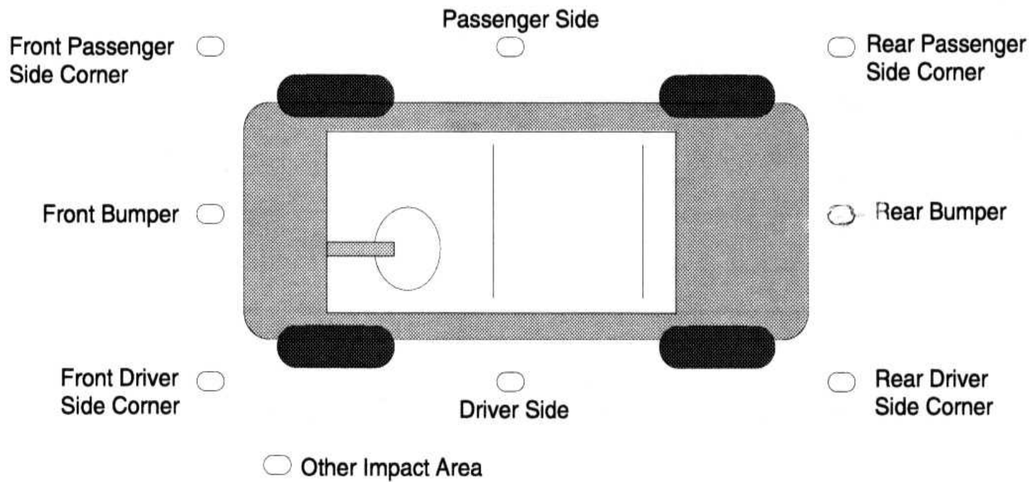
Date of Accident: ___/___/_____

1.) **Just before the accident:**

My vehicle was: ☐ At a traffic light ☐ At a stop sign going straight ☐ Making a ☐ right/ ☐left turn
☐ Traveling staight ☐ Stopped for traffic ahead ☐ Entering traffic from a side street/driveway
Traveling at _____mph ☐ Other____

Other vehicle: ☐ hit me in the rear ☐ Was Stopped ☐ ran a light ☐ Making a ☐ right/ ☐left turn
☐ Entering traffic from a side street/driveway ☐ ran across my lane
☐ other___________________________________

2.) **Mark with "X" where you were sitting - and then fill in the bubble where your vehicle was hit:**



3.) **Describe the situation by checking the correct boxes:**

☐ I was the driver involved in a: ☐ auto accident ☐ other accident: ___________________________
☐ I was the passenger involved in a: ☐ auto accident ☐ other accident: ___________________________
If passenger, I was sitting in: ☐ middle front seat ☐ right front seat ☐ left rear seat
☐ middle rear seat ☐ right rear seat
☐ I was a pedestrian: ☐ standing ☐ sitting ☐ riding a bike ☐ walking ☐ other

The Accident occurred in: city:________________________________ state: ______________________

4.) **Describe the type of vehicle:** Year:___________ Make:____________________ Model:___________________
☐economy car ☐mid-size car ☐full-size car ☐truck ☐SUV ☐van ☐heavy duty
Transmission type: ☐ manual ☐ automatic

5.) **Describe the outside environment:**

Road conditions were: ☐ dry ☐ damp ☐ wet ☐ dark ☐ clear ☐ raining ☐ ice ☐ snow
Visibility was: ☐ poor ☐ fair ☐ good
The road was made of: ☐ concrete ☐ asphalt ☐ gravel ☐ dirt ☐ other_________________

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6.) Describe the inside environment:

Did your vehicle have a head rest: ☐ yes ☐ no
If your car had a head rest, what position was it in: ☐ up ☐ middle ☐ down

Were you wearing your seat belt? ☐ yes ☐ no
Did your air bag deploy? ☐ yes ☐ no ☐ vehicle did not have air bags

My head position at the time of the accident was looking:
☐ straight ahead ☐ to the right ☐ to the left ☐up ☐ down ☐other_______________

Brakes: Were your brakes applied at the time of impact? ☐ yes ☐ no

7.) Describe what happened to your body at the time of the accident:

Elbows: My ☐ left ☐ right was on the arm rest. Other_________________________
Hands: ☐both ☐ right ☐ left was on the steering wheel.
☐ Can't remember ☐ other____

Your hands, as a result of the impact:
☐ grabbed the steering wheel tightly ☐ were forced off the steering wheel / stick shift
☐ other____

Were you aware of the impending collision before it happened? ☐ yes ☐ no
Did you tighten your body and brace for the collision? ☐ yes ☐ no

As a result of the impact, your body was thrown: ☐ forward ☐ backward ☐ right ☐ left
☐ turned to the right (clockwise) ☐ turned to the left (counter clockwise) ☐ can't remember

As a result of the impact, your head hit the: ☐ front windshield ☐ rearview mirror
☐ steering wheel ☐ The seat in front of me ☐ side driver / passenger ☐ inside window / door
☐ another person's body ☐ back of my head hit the headrest ☐ other_______________________
☐nothing

As a result of the impact, your shoulders were: ☐ impacted with the inside of the door / car
☐ pressed firmly against the shoulder harness ☐ other____

As a result of the collision, what other parts of your body struck the inside of the vehicle:
☐ ankles ☐ elbows ☐ face ☐ chest ☐ thighs ☐ forearms ☐ back
☐ other____

Were you wearing your glasses or hat at the time of the accident? ☐ none ☐ yes ☐ no
If yes, were your glasses/hat still on following the accident? ☐yes ☐ no

Did you lose consciousness as a result of the accident? ☐ yes ☐ no
If yes, how long were you unconscious:____

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8.) Describe what happened to the vehicle:

Did another car hit you: ☐ yes ☐ no
Did your vehicle strike or impact with a second object after the first impact? ☐ yes ☐ no
Did your vehicle strike a ☐ Car ☐ truck ☐ road/median ☐ building ☐ other:________________

Damage to my vehicle was ☐ mild ☐ moderate ☐ severe
Damage to other vehicle was ☐ mild ☐ moderate ☐ severe
After the accident the vehicle was: ☐ totaled ☐ drivable ☐ not drivable

At the time of the accident, how many people were in the car with you: ___________
Names of the occupants:
1.____________________________________
2.____________________________________
3____________________________________
4.____________________________________
5.____________________________________
6.____________________________________

Were the other occupants injured? ☐ yes ☐ no If yes, explain:____________________________
Were the police called to the scene? ☐ yes ☐ no
Was a police report written? ☐yes ☐ no
Was a ticket given to you? ☐ yes ☐ no
Was a ticket given to the other driver? ☐ yes ☐ no

9.) Describe how you felt after the accident:

As a result of the accident I felt my symptoms:
☐ Immediately ☐ within one hour ☐ within 6 hours ☐ during the night
☐ Next morning ☐ Next day ☐ other____
As a result of the accident I felt:
☐ headaches ☐ upper back pain ☐ chest pain/soreness ☐ wrist / elbow pain / soreness
☐ neck pain ☐ low back pain ☐ stomach pain/soreness ☐ knee/ankle pain/soreness
☐ shoulder pain ☐ numb/tingling/burning arms ☐ numb/tingling/burning legs
☐ loss of bowel / bladder control list all other symptoms_____________________________________

Please list location of any cuts or bruises if applicable:____
Did you go to the hospital? ☐ yes ☐ no
If no, where did you go? ☐ home ☐ work ☐ your primary Doctor
If yes: ☐ immediately ☐ next day ☐ later in same ☐ other___________________________
Did you go to the hospital by: ☐ ambulance ☐ private transportation ☐ drove self
☐ someone else drove
Name of hospital____City_________________________

Were you admitted to the hospital from another provider? ☐ yes ☐ no
If yes, how long was your stay:____
Hospital treatment: ☐ Exams ☐ x-rays ☐ lab work

What follow-up recommendations were made? ☐ see your medical doctor ☐ see orthopedist / neurologist
☐ physical therapist ☐ braces/collars ☐ released
☐ prescription: what types__________________________
☐ see your chiropractor ☐ Other: _________________

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Auto Accident Information

Please list all doctors you have seen since the accident

Doctor's Name First Visit Date Treatment City

1.____ Released ☐ yes ☐ no
2.____ Released ☐ yes ☐ no
3.____ Released ☐ yes ☐ no
4.____ Released ☐ yes ☐ no

Please list any special tests ordered by the hospital or doctor:____________________________

10. Please Describe your brief health history:

Please indicate below any symptoms or conditions you are currently experiencing or have in the past:

☐ Allergy ☐ Anemia ☐ Ankle Pain ☐ Asthma ☐ Arthritis ☐ Spinal Curvature
☐ Bursitis ☐ Chest Pain ☐ Diabetes ☐ Dizziness ☐ Depression ☐ Menstrual Cramps
☐ Fatigue ☐ Flat Feet ☐ Headaches ☐ Heart Attack ☐ Ulcers ☐ High Blood Pressure
☐ Hot Flashes ☐ Knee Pain ☐ Nervousness ☐ Eye pain ☐ Osteoporosis ☐ Low Blood Pressure
☐ Cancer ☐ Colitis ☐ Fainting ☐ Kidney Pain ☐ Stroke ☐ Abdominal Pain
☐ Sinus Trouble ☐ Shoulder Pain ☐ Back Pain ☐ Thyroid Disease ☐ Painful Urination
☐ Rheumatic Fever ☐ Numbness in Hands ☐ Numbness in Feet ☐ Other ________________

Do you have any previous fractures, dislocations, spinal injuries, surgeries, serious injuries, or illnesses not listed above?

☐ No ☐ Yes, please explain: ________________________________

Do you use tobacco? ☐ No ☐ Yes, how much: ________________
Do you use alcohol? ☐ No ☐ Yes, how much: ________________
Do you use caffeine? ☐ No ☐ Yes, how much: ________________
Do you take any medications or vitamins: ☐ Yes ☐ No

a. If yes, please list:
____

11.) Describe your current work status:

Are you working now? ☐ yes ☐ no
Were you employed at the time of this accident? ☐ yes ☐ no

Type of work you do?: ____________________________
Are you currently working with restrictions? ☐ yes ☐ no
Has the doctor placed you on: ☐ total disability ☐ partial disability ☐ does not apply

Please list work restrictions if applicable: ____________________________

12.) Describe the intensity of your symptoms:

Since the accident do you feel: ☐ worse ☐ no improvement ☐ better ☐ other__________

Pain Scale On a scale of one to ten, please circle how you would rate your pain. 10 being the worst:

1 2 3 4 5 6 7 8 9 10

ADDITIONAL NOTES:

____

____

Auto Insurance Information Form

Montrose Family Chiropractic
145 Nelson Blvd Ste 1000
PO Box 406
Montrose, MN 55363

Patient Name: ______________________________ **Date of Birth:** ______________
Last , First , Middle Initial Month / Day / Year

Address: ______________________________
Mailing Address City State Zip Code

Phone: Home Phone: (_________)________________ Cell Phone:(_________)________________
What number would you rather be reached at: ☐Home Phone Number ☐ Cell Phone Number

Social Security Number: ______________________ **Email Address:** ______________________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Other **Spouse Name:** ______________

Employers Name: ______________________ **Work phone number:** (________)______________

Emergency Contact: ______________________________
Last First Phone number

Do you have Auto Insurance and Health Insurance? ☐ **No, I just have Auto insurance** (fill out section A and C)
☐ **Yes** (Fill out Section A, B, and C)

______________ ______________ ______________ ____ ________
Auto Insurance Name, Address of Insurance Company, City, State, Zip Code

Claims Adjuster's Name: ______________________ Claims Adjuster's phone number: (______)______________

Are you the Primary name on this Insurance policy? ☐ Yes ☐ No **Date of Crash:** ______________

If No, then who is: ______________ ______________ ______________ ______________
Last name, First name Social Security Number Date of Birth Relationship to Insured

Policy/ID Number: ______________________ **Claim Number:** ______________

______________ ______________ ______________ ____ ________
Health Insurance Name, Address of Insurance Company, City, State, Zip Code

Are you the Primary name on this Insurance policy? ☐ Yes ☐ No

If No, then who is: ______________ ______________ ______________ ______________
Last name, First name Social Security Number Date of Birth Relationship to Insured

Policy/ID Number: ______________________ **Group Number:** ______________

I authorize the release of any medical or other information to Montrose Family Chiropractic as necessary to process this claim. I also request payment of medical benefits from either a government or non-government source to Montrose Family Chiropractic. I authorize Montrose Family Chiropractic to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered, and I understand that I will be charged 1.5% monthly or (18% annual percentage rate) with a minimum monthly fee of $1.00, on any non-contract insurance balances over 30 days. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred with collection if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged for $30.00 for each returned check. While Montrose Family Chiropractic will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be determined as self-pay and due in full by myself. I certify this information is true and correct to the best of my knowledge.

Signature: ______________________________ **Date:** ______________