MONTROSE
FAMILY CHIROPRACTIC

Auto insurance information

Montrose Family Chiropractic
145 Nelson Blvd suite 1000
Po box 406, Montrose, MN 55363
763-330-2302

Patient name: _____ **Date of birth:** _____
Last First Middle initial month/day/year

Address: _____
Street Address po box city state zip code

Phone: Home: _____ Cell: _____

Social Security Number: _____ **Email:** _____

Sex: Male Female **Marital Status:** Single other Spouse Name: _____

Employers name: _____ **Work Phone Number:** _____

Emergency contact: _____ **Phone Number:** _____

Do you have auto and health insurance? **Yes** (fill out next section) **No** (skip next section)

_____ _____ _____ _____ _____
Auto Insurance Name, **Address of Insurance,** **City** **State** **Zip Code**

Claim adjusters name: _____ **Claim Adjusters phone number:** _____

Ave you the primary name on this Insurance Policy? **Yes** **No** **Date of crash:** _____

If no, then who is? _____ _____ _____ _____ _____
Last name First Name SSN Date of birth Relationship to insured

Policy/ID Number: _____ **Claim Number:** _____

_____ _____ _____ _____ _____
Primary Insurance Name, **Address of Insurance,** **City** **State** **Zip Code**

Ave you the primary name on this Insurance Policy? **Yes** **No**

If no, then who is? _____ _____ _____ _____ _____
Last name First Name SSN 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 $40.00 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:** _____

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Auto Accident Information

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

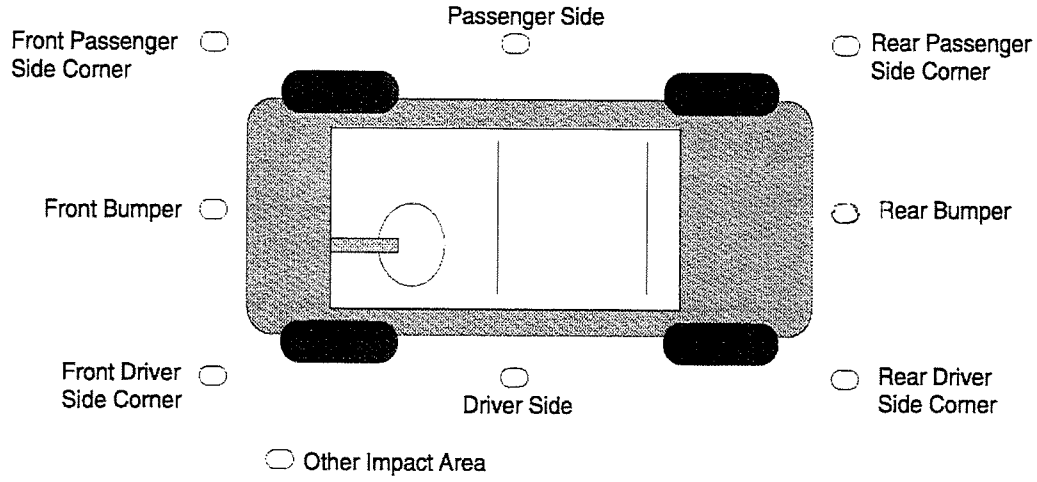
Date of Accident: ___/___/_____

1.) Just before the accident:

My vehicle was: ☐ At a traffic light ☐ At a stop sign going straight ☐ Making a ☐ right/ ☐left turn
☐ Traveling straight ☐ 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:_____

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:_____

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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._____

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: _____

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

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

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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_____

Family medical Doctor: _____ Clinic:_____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

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:

_____

_____

Patient Signature_____ Date_____
(or legal guardian)

Problem Checklist

The purpose of this questionnaire is to help us understand how your injury has affected you. Please use the following numbering scheme to answer the questions below.

No for 0
No problem for 1 or 2
Moderate problem for 3-5
Severe problem for 6 or 7

1. Visual problems.	0	1	2	3	4	5	6	7
2. Hearing difficulties.	0	1	2	3	4	5	6	7
3. Poor balance.	0	1	2	3	4	5	6	7
4. Doing things slowly.	0	1	2	3	4	5	6	7
5. Difficulty pronouncing words clearly.	0	1	2	3	4	5	6	7
6. Problems with Coordination.	0	1	2	3	4	5	6	7
7. Fatigue quickly; get tired easily.	0	1	2	3	4	5	6	7
8. Headaches.	0	1	2	3	4	5	6	7
9. Dizziness/vertigo.	0	1	2	3	4	5	6	7
10. Sensitivity to noise.	0	1	2	3	4	5	6	7
11. Sensitivity to light.	0	1	2	3	4	5	6	7
12. Problems with taste or smell.	0	1	2	3	4	5	6	7
13. Difficulty finding the right word.	0	1	2	3	4	5	6	7
14. Expressing self in wordy, roundabout way.	0	1	2	3	4	5	6	7
15. Being easily distracted.	0	1	2	3	4	5	6	7
16. Poor concentration for extended periods of time.	0	1	2	3	4	5	6	7
17. Being forgetful; difficulty remembering things.	0	1	2	3	4	5	6	7
18. Difficulty thinking clearly and efficiently.	0	1	2	3	4	5	6	7
19. Difficulty planning and organizing things.	0	1	2	3	4	5	6	7
20. Difficulty setting realistic goals.	0	1	2	3	4	5	6	7

21. Difficulty following through or finishing things.	0	1	2	3	4	5	6	7
22. Apathy, lack of interest in things.	0	1	2	3	4	5	6	7
23. Lack of initiative, do not start things up.	0	1	2	3	4	5	6	7
24. Irritability.	0	1	2	3	4	5	6	7
25. Restlessness.	0	1	2	3	4	5	6	7
26. Temper outbursts.	0	1	2	3	4	5	6	7
27. Mood swings, quick emotional shifts.	0	1	2	3	4	5	6	7
28. Difficulty bringing emotions under control once expressed.	0	1	2	3	4	5	6	7
29. Getting into arguments with others.	0	1	2	3	4	5	6	7
30. Being physically violent.	0	1	2	3	4	5	6	7
31. Getting bored easily.	0	1	2	3	4	5	6	7
32. Complaining about things.	0	1	2	3	4	5	6	7
33. Dependency on others.	0	1	2	3	4	5	6	7
34. Needing supervision.	0	1	2	3	4	5	6	7
35. Anxiety/tension.	0	1	2	3	4	5	6	7
36. Depression.	0	1	2	3	4	5	6	7
37. Loneliness.	0	1	2	3	4	5	6	7
38. Loss of confidence.	0	1	2	3	4	5	6	7
39. Changes in appetite.	0	1	2	3	4	5	6	7
40. Sleep disturbance.	0	1	2	3	4	5	6	7
41. Low sexual drive.	0	1	2	3	4	5	6	7
42. High sexual drive.	0	1	2	3	4	5	6	7
43. Changed personality.	0	1	2	3	4	5	6	7

Whiplash disability questionnaire

This questionnaire has been designed to provide information on the impact that your whiplash injury and symptoms have upon your lifestyle. Please circle the number in each section to indicate how you have been affected by the whiplash injury and symptoms. If one or more questions are not relevant to you, please leave the section blank.

DATE _____

0- No or not at all
10-Worst or unable

1. **How much pain do you have today?**
   0 1 2 3 4 5 6 7 8 9 10
2. **How much do your whiplash symptoms interfere with your personal care? (washing, dressing)**
   0 1 2 3 4 5 6 7 8 9 10
3. **How much do your whiplash symptoms interfere with your work/home/study duties?**
   0 1 2 3 4 5 6 7 8 9 10
4. **How have your whiplash symptoms interfere with driving or using public transport?**
   0 1 2 3 4 5 6 7 8 9 10
5. **How much do your whiplash symptoms interfere with sleep?**
   0 1 2 3 4 5 6 7 8 9 10
6. **How often do you experience tiredness/fatigue because of your whiplash injury/symptoms?**
   0 1 2 3 4 5 6 7 8 9 10 (always)
7. **How much do your whiplash symptoms interfere with social activity?**
   0 1 2 3 4 5 6 7 8 9 10
8. **How much do your whiplash symptoms interfere with sporting activity?**
   0 1 2 3 4 5 6 7 8 9 10
9. **How much do your whiplash symptoms interfere with non-sporting leisure activity?**
   0 1 2 3 4 5 6 7 8 9 10
10. **How often do you experience sadness/depression because of your whiplash/symptoms?**
    0 1 2 3 4 5 6 7 8 9 10(always)
11. **How often do you experience anger because of whiplash injury/symptoms?**
    0 1 2 3 4 5 6 7 8 9 10(always)
12. **How often do you experience anxiety because of your whiplash/symptoms?**
    0 1 2 3 4 5 6 7 8 9 10(always)
13. **How much difficulty do you have concentrating because of your whiplash/symptoms?**
    0 1 2 3 4 5 6 7 8 9 10
14. **How has your condition changed over the past month?**
    Very much worse no change very much better