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

# Work Injury Information

**Patient's Name: _____ _____ Today's Date: _____**
Last, First

Date of Injury: _____

Please describe how the injury happened in detail: _____

_____

_____

_____

Have you reported your injury to your employer: ☐ yes ☐ no

If no. Explain:_____

Was there a witness? ☐ No ☐ Yes, who: _____

Did the company file a First Report of Injury: ☐ No ☐ Yes

When did you report your injury: _____ To whom:_____

Did you work the rest of your shift: ☐ yes ☐ no If yes, how many hours?_____

Did you receive temporary total disability (TTD): ☐yes ☐ no If yes, from who? Dr._____

Did you receive temporary partial disability (TPD): ☐ yes ☐ no If yes, from who? Dr._____

Are you working now: ☐ yes ☐ no

When did you return to work? _____How many work days did you lose?_____

How many hours did you work when you returned to work: _____

Are there limitations as a result of the injury? ☐ yes ☐ no
If yes. Explain changes and limitations:_____

_____

Are you still working at the same job? ☐ yes ☐ no
If you are still working at same employer, has your job description changed? ☐ yes ☐ no

If your employment has changed, present job involves:
☐ office work only ☐ some light lifting
☐ repetitive lifting of____Ibs ☐ maximum lifting up to_____Ibs.
☐ repetitive squatting ☐ repetitive bending ☐ repetitive stooping
☐ repetitive kneeling ___hours per day/___ days per week
☐ other:_____

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## Work Injury Information

How long have you been employed with former company:_____

How long have you been employed with present company:_____

Please list former employers - list company names:

1. _____ Injuries ☐ yes ☐ no
2._____ Injuries ☐ yes ☐ no
3._____ Injuries ☐ yes ☐ no
4._____ Injuries ☐ yes ☐ no

As a result of this accident, did you go to the hospital: ☐ yes ☐ no

If yes, please name the hospital: _____City_____

If yes: ☐ immediately ☐ next day ☐ later in same day ☐ other_____

Did you go to the hospital by: ☐ ambulance ☐ private transportation

If yes, how long was your stay? _____

Hospital diagnosis: _____

What recommendations were made: ☐ see your own doctor ☐ see orthopedist/neurologist
☐ physical therapist ☐ braces/collars ☐ prescription ☐ released
☐ see your chiropractor ☐ other_____

Please list all doctors you have seen as related to the accident:

Name Address City Released

1._____

2._____

3._____

4._____

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

_____

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## Work Injury Information

What injuries did you sustain? _____

_____

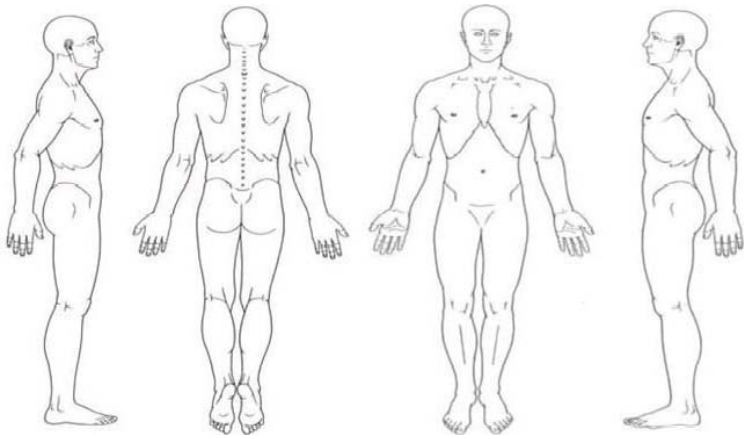
_____

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasional (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ☐ Sharp
- ☐ Dull
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling
- ☐ Stabbing
- ☐ Achy



**Please indicate where you have pain or other symptoms on the drawing**

Did you experience immediate symptoms: ☐ yes ☐ no

If no, when did they first appear?_____

What were your first 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:

_____

_____

_____

_____

_____

_____

# Work Injury Insurance Information Form

**Montrose Family Chiropractic**
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**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:** _____

**Emergency Contact:** _____
Last First Phone number

_____ _____ _____ _____ _____
Work. Comp. Insurance Name, Address of Insurance Company, City, State, Zip Code

Claims Adjuster's phone number: (_____)_____ Ext.: _____

Claims Adjuster's FAX number: (_____)_____Claims Adjuster's Name: _____

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

Do you have personal Health Insurance too? ☐ No ☐ Yes, what type: _____

_____ _____ _____ _____ _____
Employer's Name, Address of Employer, City, State, Zip Code

Is your employer part of a managed care network? ☐ Yes ☐ No ☐ I'm not sure

**Employer's Phone Number:** _____ **Contact Name:** _____

**Date of Injury:** _____ **Time of Injury:** _____

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:** _____