*If the reason for your visit is due to a worker's compensation injury or an automobile accident, please inform the front desk immediately.

PERSONAL INFORMATION

Date_____

_____ Date of Birth _____
(Last) (First) (M.I.)
Address _____ City/State _____Zip _____

Cell # _____Work # _____Email_____

Sex: M F Other Marital Status: S M D W

Occupation _____ Employer _____

MD'S Name _____ Clinic/Location _____

Parent's Name (if Minor) _____ Spouse's Name _____

Subscriber _____ Subscriber's Date of Birth _____

Insurance Carrier _____ Subscriber's Employer _____

Group /Policy # _____ ID # _____

Past Chiropractic Care □ Yes □ No When _____ Chiroprator's Name _____

How did you hear about Exuberance Chiropractic & Wellness Center?_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me. If I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due.

I hereby authorize the Doctor to examine and treat my condition as deemed appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for x-rays is for the examination of only, and the x-ray films will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I also agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's/Guardian's Signature _____ Date _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

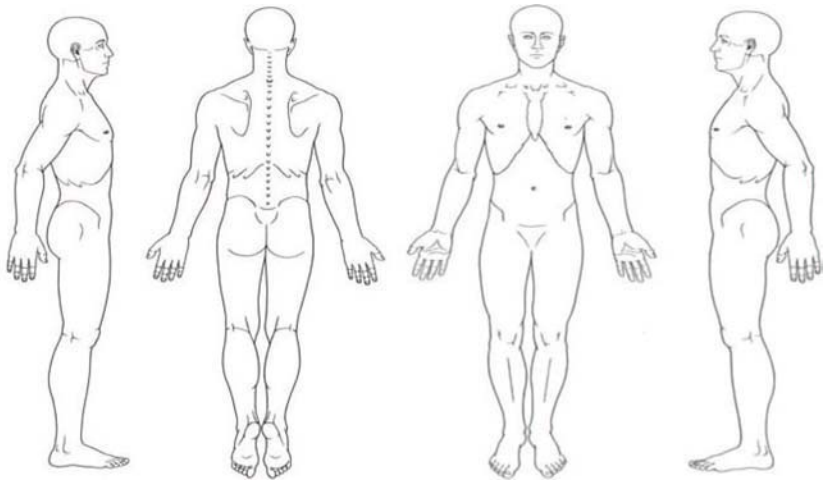
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

---

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] *Feet Inches* Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer	○	○	
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

exuberance
Chiropractic & Wellness Center

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other procedures including, but not limited to, various modes of therapy, rehabilitation, massage, and if necessary diagnostic x-rays on me (or on the patient named, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such services may be performed by the Physician of Chiropractic listed above and/or other licensed Physicians of Chiropractic or other professionals who may treat me now or in the future at this office. I have had an opportunity to discuss with the doctor and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all health care, the practice of Chiropractic or other services carry some risks to treatment including but not limited to: fractures, disc injuries, strokes (CVA), dislocations, sprains, and burns. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure(s) which the physician feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content. By signing below I agree to the treatment recommended by the physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Print Patient Name _____

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

This form should be maintained in the patient's health record.

Exuberance Chiropractic & Wellness Center
17830 Kenwood Trail Lakeville, MN 55044 952-435-3345

Exuberance Chiropractic & Wellness Center
17830 Kenwood Trail
Lakeville, MN 55044
(952)-435-3345

(Consent to use PHI) Notice of Privacy Practices - Acknowledgment & Consent

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Exuberance Chiropractic & Wellness Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____

Patient or Legally Authorized Individual Signature Date

_____ _____

Print Patients Full Name Time

_____ _____

Witness Signature Date

Non-**Covered Services: Financial Disclosure Form**

Provider Name: Exuberance Chiropractic & Wellness Center
Address: 17830 Kenwood Trail, Lakeville MN 55044
Phone Number: (952) 435-3345

As your Doctor of Chiropractic, I want to provide you with the best care possible. While your policy covers some chiropractic services, there may be others that I feel would help the treatment of your condition and maintenance of good health, but are not covered by your health insurance coverage. If you agree to receive these services, and they are later determined to not be eligible for reimbursement through your health plan policy, your signature on this form signifies your agreement to pay for them in full. While you may choose to not obtain these services, I want to reassure you that I will only recommend care that I believe will benefit your health.

Chiropractic services typically covered by health insurance policies include:

- Chiropractic manipulations to treat a clinical condition
- Treatment that has the potential to significantly improve a clinical condition
- Limited treatment of symptom flare-ups or exacerbations where a permanent condition exists.

Services that we expect to not be eligible for reimbursement through your plan's chiropractic benefit, and therefore will likely be your financial responsibility should you elect to receive them, are outlined below. Your financial responsibility is limited to services received

Non-Covered Services	Cost per Visit	Member Initials/Date
Exam(s) ($40, $59, $80, $109)	$40-$109	
Manipulation Spinal ($40, $60) / Extremity ($20)	$40-$60	
X-ray(s)	$75	
Therapies/Modalities (Circle All Applicable Therapies) Electrical Stimulation ($20) Traction ($20) Ultrasound ($21) Other:_____	$20-$21	
Durable Medical Equipment (Circle All Applicable Products) Braces($46) Tens Unit($99) Orthotics($199) Heel Lift($6) Bio Freeze($15) Ice Pack($10, $18, $25) Foam Roller($14, $15, $32) Flex Bands($8, $10, $15, $20, $24, $26, $28, $34 Nub($2) Handle($6) Ball($18) Other: _____	$9-$199	
Massage ($21.05 per 15 minutes)	$18-$99	
Rehabilitation ($20-$35)	$30	
Total:		

I believe these services will not be eligible for reimbursement through your health plan because (check one):

- ☐ They are maintenance or elective care rather than treatment to improve a clinical condition
- ☐ They are excluded from your chiropractic coverage, even when related to treatment to improve a clinical condition

Provider/Authorized Healthcare Representative Signature: _____ Date: _____

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability, and other covered treatment alternatives, and the provider/staff has answered them to my satisfaction. I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total billed charge(s) related to non covered services.

Patient's Name: _____ Date:_____

Patient's Signature: _____

A copy of this signed form must be provided to the patient upon request

Financial Policy

TO OUR PATIENTS: It is our hope that you will understand our credit and collection policies are a necessary part of assuring the financial resources required to maintain this vital health care service for our patients. Please assist us in our efforts by staying current with your financial responsibilities. For this reason, we have developed the following policies:

WITH INSURANCE: As a courtesy to our patients we will bill your insurance company directly. For this reason, we ask that you bring your insurance card to your appointments. Please inform the front desk prior to your visit if your insurance has changed. It is suggested that you familiarize yourself with your chiropractic coverage. You are responsible for any office visit copay and payment for such is expected each day of service, we do not bill for copays. If your insurance plan has a deductible and we know the fee schedule, we will ask for such amount on a per visit basis. We will do everything possible to determine your coverage, however, nothing is final until the claims are processed by your carrier.

DOUBLE COVERAGE: We will bill both insurance carriers for services performed. It is your responsibility to pay for any services not covered after both insurances have processed your claim.

MEDICARE: We will do everything possible to determine coverage. However, if there are services performed that are necessary for your treatment but are not covered by your plan, you are responsible for such charges.

WORKERS COMPENSATION, AUTO ACCIDENTS AND PERSONAL INJURY: As a courtesy to you we will file all necessary reports and bill the involved insurance carrier. With these claims, you bear no financial responsibility unless: 1) your claim is denied by the insurance carrier or, 2) they deny certain coverage, for example supports.

WITHOUT INSURANCE: A cash discount of 10% is given and payment is due on a per visit basis.

ITEMS AVAILABLE FOR PURCHASE: Such as orthopedic supports, pillows or ice packs. These items are not covered by insurance and payment is due at time of purchase.

GENERAL: If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to personally discuss the matter with us. This will avoid misunderstanding and enable you to keep your account in good standing.

There will be a $20 service charge for returned checks and your account may be subject to payment by cash or credit card for future visits.

_____ _____

Signature Date

Workers Compensation Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help. If we do not sincerely believe your condition will respond satisfactory, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Sex_____ Date of Birth _____SSN.# _____
Address_____ City_____
State_____ Zip_____
Phone_____Occupation_____Employer_____
Location_____Business Phone_____
Marital Status_____ Spouse's Name _____Spouse's Employee_____

Who referred you to our office?_____

Please explain in detail how your accident happened_____
_____
_____
_____

Have you retained an attorney? □ Yes □ No Litigation? □ Yes □ No □ Maybe
If so, name and address_____
Give time and date present injury occurred_____ □ AM □ PM _____, 20_____
Where did you feel pain immediately after the accident?_____
Did you consult any other doctors? □ Yes □ No Did you return to work? □ Yes □ No
If so, give doctor's name_____ □ D.C., □ M.D., □ D.O., □ D.D.S.
Doctor's diagnosis_____
What treatment did you receive?_____
Have you ever injured this area before? □ Yes □ No If yes, when?_____
If injured before, did you lose time for work? □ Yes □ No
If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted_____
_____
Do any other diseases or accidents affect your employment? □ Yes □ No If yes, explain_____
_____
In your work do you have to favor any part of your body? □ Yes □ No If yes, explain_____
_____
Do you have a history of absenteeism caused from accidents on the job? □ Yes □ No
Have you ever had a Workers Compensation claim before? □ Yes □ No
Before the injury were you capable of working on an equal basis with others your age? □ Yes □ No
Are your work activities restricted as a result of this accident? □ Yes □ No
Since this injury are your symptoms □ improving? □ getting worse? □ the same?

Date:_____ Patient's Signature:_____

Automobile Accident Questionnaire
Please answer all questions completely

This information is considered confidential. We need this information because we care enough to want to know, and 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. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Sex_____ Date of Birth_____ Social Sec.# _____
Address_____ City_____ State_____ Zip_____
Phone_____Occupation_____(Indicate if child, student, housewife, unemployed, retired)
Employer_____ Location_____ Business Phone_____
Marital Status_____ Spouse's Name _____Spouse's Employer_____

Who referred you to our office?_____

Please explain in detail how your accident happened
_____
_____
_____
_____

Insurance Co._____ Policy No._____ Claim No._____

Driver of other vehicle (if any)
Name_____ Insurance Company_____ Policy No._____

Driver of vehicle in which you were injured (if applicable)
Name_____ Insurance Company_____ Policy No._____
Name of your insurance adjuster_____ Have you retained an attorney? □ YES □ NO
If so, name and address_____
You were heading □ North □ East □ South □ West on_____(street or highway)
Other vehicle was headed □ North □ East □ South □ West on_____(street or highway)
Were police notified? □ Yes □ No Were you knocked unconscious? □ Yes □ No If yes, for how long?_____
You were struck from □ Behind □ Front □ Left Side □ Right Side
You were □ Driver □ Passenger □ Front Seat □ Back seat □ Using Seat Belts □ Other protective devices
What was the time and date of present injury?_____
Where did you feel pain immediately after the accident?_____
Where were you taken after the accident?_____
What treatment was given?_____
Was any other doctor consulted after your accident? □ Yes □ No
If so what was the doctor's name?_____ □ D.C., □ M.D., □ D.O., □ D.D.S.
What was the diagnosis?_____
What treatment was given?_____
How often did you see the doctor?_____
How long did you see the doctor?_____
Have you ever had any complaints in the involved area before? □ Yes □ No
If so, what were the complaints?_____
Before the injury, were you capable of working on an equal basis with others your age? □ Yes □ No
Are your work activities restricted as a result of this accident? □ Yes □ No
Since this injury are your symptoms □ Improving? □ Getting worse? □ Same?

Date:_____ Patient's Signature_____