VEHICLE ACCIDENT QUESTIONNAIRE

This information will be strictly confidential. Your answers will help us determine if chiropractic care will benefit you. Plesase print and be as accurate and complete as possible.

Thank you - Schmidt Chiropractic Center

PATIENT INFORMATION

NAME Last	First	Middle	DATE
ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE

SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT	WEIGHT	SEX

EMPLOYER	OCCUPATION
BUSINESS ADDRESS	EMAIL ADDRESS

ACCIDENT INFORMATION

GIVE DETAILS OF HOW ACCIDENT OCCURRED

DATE & TIME OF ACCIDENT:	WERE POLICE NOTIFIED? YES NO (Circle One)	WERE YOU USING A SEATBELT? YES NO (Circle One)	YOU WERE (Circle Option): Driver Passenger Front Seat Back Seat

VEHICLE WAS HEADING: (Circle option) North South East West ON: _____ Hwy/Street	THE OTHER VEHICLE WAS HEADING: North South East West ON: _____ Hwy/Street

WHERE WERE YOU TAKEN AFTER THE ACCIDENT?	DOCTORS NAME:	HOW OFTEN DID YOU SEE THIS DOCTOR?
WERE YOU UNCONSCIOUS? IF YES, HOW LONG? YES NO (Circle One)	WHAT TREATMENT WAS AND DIAGNOSIS WAS GIVEN?	

IF YOU CONSULTED ANOTHER DOCTOR, GIVE NAME, ADDRESS & PHONE#:

PLEASE DESCRIBE YOUR INJURIES AND SYMPTOMS RESULTING FROM THIS ACCIDENT:

SINCE THIS INJURY ARE YOUR SYMPTOMS: (Circle Selection that applies)

Improving The Same Getting Worse

LIST TWO MAJOR COMPLAINTS, AND CIRCLE THE INTENSITY OF PAIN

Low 1-3, Moderate 4-6, Intense 7-9, Emergency 10

COMPLAINT 1: _____ 1 2 3 4 5 6 7 8 9 10

COMPLAINT 2: _____ 1 2 3 4 5 6 7 8 9 10

DID YOU OR ARE YOU STILL TAKING ANY MEDICATIONS FOR THIS INJURY?
YES NO (Circle One)

ANY PRIOR INJURIES OR SYMPTOMS TO THE SAME AREA(S)?
YES NO (circle) HOW:

HAS INJURY RESTRICTED YOUR WORK? IF YES, IN WHAT WAY?
YES NO (circle) EXPLAIN:

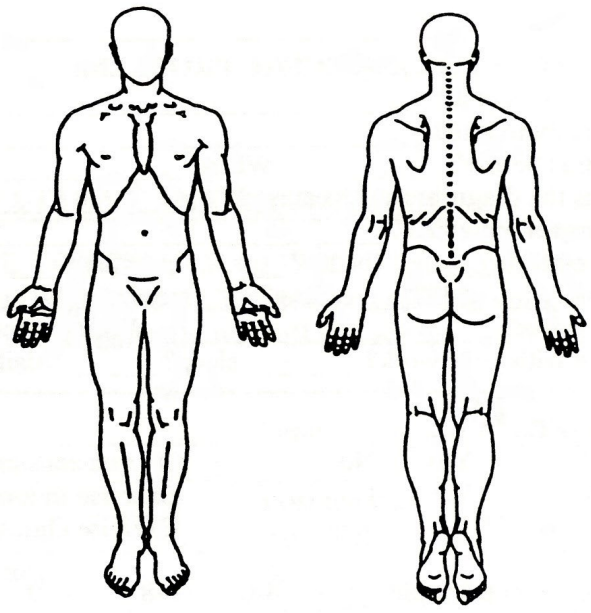
DID YOU RETURN TO WORK? IF NO, HOW LONG WERE YOU OFF?
YES NO (circle) EXPLAIN:

BEFORE THIS INJURY WERE YOU ABLE TO WORK ON AN EQUAL BASIS WITH OTHERS YOUR AGE?
YES NO (circle)

HAVE YOU RETAINED AN ATTNORNEY?
YES NO (circle) Attorney's name:

Attorney Address & Phone	IS THERE LITIGATION? (Cirlce) Yes No Maybe If Yes Explain:

Mark the areas of Pain Resulting from this accident on the figure below:



PATIENT CONDITION

Type of pain (circle): Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your (circle any): Work Sleep Recreation Daily Routine

Activities or movements that are painful to perform (circle any): Sitting Standing Walking Bending Lying Down

HEALTH HISTORY

What treatments have you already received for your condition? (circle any) Medications Surgery Physical Therapy
Chiropractic None Other: _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of last: Physical Exam: _____ Spinal X-Ray: _____ Blood Test: _____
Spinal Exam: _____ Chest X-Ray: _____ Urine Test: _____
Dental X-Ray: _____ MRI ,CT-Scan, Bone Scan: _____ Mammogram: _____

Please circle " Y" for YES or a "N" for NO to indicate if you have had any of the following:

AIDS/HIV	Y	N	Fractures	Y	N	Parkinson's Disease	Y	N	Other (please list)
Alcoholism	Y	N	Glaucoma	Y	N	Pinched Nerve	Y	N	
Allergies	Y	N	Goiter	Y	N	Pneumonia	Y	N	
Anemia	Y	N	Gonorrhea	Y	N	Polio	Y	N	
Anorexia	Y	N	Gout	Y	N	Prostate Problem	Y	N	
Appendicitis	Y	N	Heart Disease	Y	N	Psyciatric Care	Y	N	
Arthritis	Y	N	Hepatitis	Y	N	Rheumatoid Arthritus	Y	N	
Asthma	Y	N	Hernia	Y	N	Rheumatic Fever	Y	N	
Bleeding			Herniated Disk	Y	N	Scarlet Fever	Y	N	
Disorder	Y	N	Herpes	Y	N	Stroke	Y	N	
Breast Lump	Y	N	High Cholesterol	Y	N	Suicide Attempt	Y	N	
Bronchitis	Y	N	Measles	Y	N	Thyroid Problem	Y	N	
Bulimia	Y	N	High Blood			Tonsilitis	Y	N	
Cancer	Y	N	Pressure	Y	N	Tuberculosis	Y	N	
Cataracts	Y	N	Migraine Headaches	Y	N	Tumor, Growth	Y	N	
Chemical			Miscarriage	Y	N	Typhoid Fever	Y	N	
Dependency	Y	N	Multiple Sclerosis	Y	N	Ulcers	Y	N	
Chicken Pox	Y	N	Mumps	Y	N	Vaginal Infection	Y	N	
Diabetes	Y	N	Osteoporosis	Y	N	Venereal Disease	Y	N	
Emphysema	Y	N	Pacemaker	Y	N	Whooping Cough	Y	N	
Epilepsy	Y	N							

Exercise (circle)

None
Moderate
Daily
Heavy

WORK ACTIVITY (circle)

Sitting
Standing
Light Labor
Heavy Labor

Habits

Smoking Packs/Day _____
Alcohol Drinks/Week _____
Coffee/Caffeine Drinks Cups/Day _____
High Stress Level Reason _____

Females

Are you Pregnant?
Yes No
Due Date _____

Injuries / Surgeries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	Allergies	Vitamins/Herbs/Minerals

AUTO CLAIM INFORMATION

Auto Carrier Name & Address

Auto Agent Name and Address

Phone#:

Phone#:

Claim#:

Fax#:

Adjuster:

ASSIGNMENT AND RELEASE

Insurance carriers for motor vehicle/personal injury accidents will pay for reasonable chiropractic care. Minnesota is a no-fault state; therefore, medical claims are paid by the patient's auto insurance, even if the accident is not the patient's fault or if you were a passenger in the vehicle. It is the patient's responsibility to inform the clinic of the auto insurance company's information.

It is further understood that the patient is 100% responsible for all services rendered. In the event that any services are not allowed and considered for payment by the auto/personal injury insurance, the patient agrees to provide proof of health insurance and is responsible for any copays and/or deductibles. If the health insurance denies payment or indicates no coverage, the patient is then responsible to make payment immediately for all services not covered.

NOTE: If services result in a lawsuit and payment is delayed due to this matter, our office will require a Letter of Protection or Lien from your attorney to await payment at time of settle, only if you remain an active patient.

The below signature acknowledges that I have read the above statement and understand the policy and financial responsibility. I also authorize direct assignment of payment for all professional services to be paid by my automobile , health insurance and or attorney to Schmidt Chiropractic Center located at 320 E Hill Street, PO Box 215, NYA, MN 55368, and realize that any balance that is non covered or remaining will be promptly paid.

Also, I further agree to allow a release of any and all medical records to my health insurance, if requested, in order to insure prompt payment on the medical claim.

Patient Signature **Date**

Patient Name

Updated 07-01-16

Schmidt Chiropractic Center

320 E Hill St, PO Box 215
Norwood Young America, MN 55368

PATIENT CONSENT FOR CHIROPRACTIC TREATMENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask your Doctor any questions that you have about the information below. You can ask questions at any time before, during, or after your treatment.

The nature of chiropractic adjustment: The primary treatment your Doctors of Chiropractic uses is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your own knuckles. You may also feel a sense of movement.

Examination and Treatment: In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following additional procedures:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Orthopedic testing
- Range of motion testing
- Basic neurological exam
- Muscle strength testing
- Ultrasound
- Radiographic studies
- Rehabilitation/core strengthening
- Nutritional therapy
- Mechanical traction/flexion distraction
- Other_____

We will explain these procedures to you and answer any questions you have about them.

The material risks inherent in chiropractic adjustment: Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

The probability of risks occurring:

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.
Fracture: Fractures caused from spinal manipulations are extremely rare. It is so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for this type of patient.
Ruptured/Herniated Disc: There have been some reports of herniated or ruptured discs caused by spinal manipulations. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.
TIA/Stroke: According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks.
Other complications: These include but are not limited to: dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.
The availability of other treatment options: Other treatment options for your condition may include:

- Self-administered, over-the-counter medications
- Medical care and prescription drugs, such as anti-inflammatories, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are also risks and benefits with each one of those options and you may wish to discuss these with your primary medical physician.

The risks and dangers associated with remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Notices of Privacy Practices: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Notice of Privacy Practices. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Consent to Release of Information:

- In accordance with Minnesota Statutes § 144.335, I consent to the release by my provider of my health records and medical information about me to physicians, providers, and staff as necessary for treatment, to insurers as necessary to receive payment for services, and to third parties for purposes of reviewing quality of care and for health care operations (so long as the release is in compliance with applicable law), including releases for internal or external audits, research and quality assurance, or licensing/accreditation purposes.
- I give my permission to my provider to communicate information about me to those people involved in my care for the purpose of my treatment as designated in my medical record.
- I give permission for my provider to communicate with me regarding my medical care, such as results of tests/reports through voicemail messages via the phone numbers I have supplied in my medical record.
- In order to assure proper quality and continuity of care, I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, or third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider, other providers from whom I have received services, or any other payer, payer network organization, or third party administrators as needed for payment and health care operations.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PATIENT CONSENT FOR CHIROPRACTIC TREATMENT

I understand this Consent to Release of Information does not expire unless I revoke it or provide a specific expiration date here: _____

I, _____, have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. **BY SIGNING BELOW, I CONSENT TO ALL OF THE USES AND DISCLOSURES ABOVE, AND I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.** I have discussed it with my provider and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Having been informed of the known risks, I hereby give my consent to that treatment. I intend this consent to apply to all of my present and future chiropractic care.

I also grant permission to communicate my personal health information to others involved in my care for the purpose of treatment, results of tests and medical care at the following numbers.
Please specify your contact preference:
_____Home Phone:_____
_____Cell phone:_____ Text: Yes or No
_____Email:_____

_____	_____	_____
Date	Signature of patient or authorized person	Authority to act on behalf of patient (Proof Required)