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

Patient Name _____ **Date** _____

1. Describe your symptoms: _____

_____

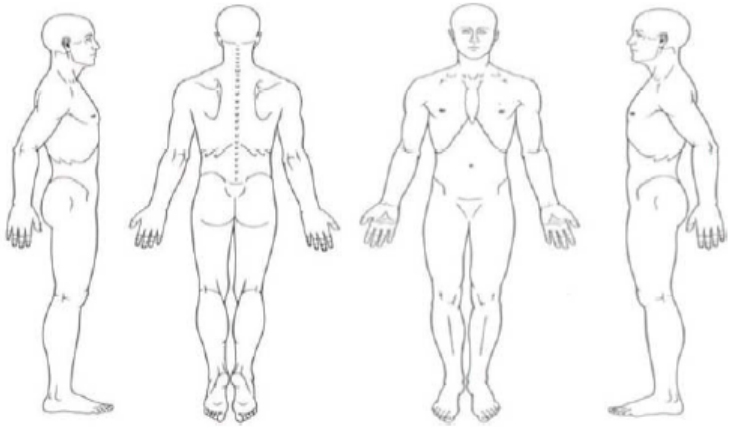
a. When did it start? _____

b. How did your symptoms begin? _____

c. If you are injured, did the injury occur at: ☐ Home ☐ Work ☐ Auto ☐ Other: _____

2. How often do you experience your symptoms?
- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms on diagram:



3. What describes the nature of your symptoms?
- ☐ Sharp ☐ Shooting
- ☐ Dull Ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?
- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. During the <u>past 4 weeks</u>:

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)?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

7. In general would you say your overall health right now is…
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. Who have you seen for your symptoms? ☐ No one ☐ Medical Doctor ☐ Other ☐ Other Chiropractor ☐ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they perfomed? ☐ Xrays (date: _____) ☐ CT Scan (date: _____) ☐ MRI (date: _____) ☐ Other (date: _____)

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

a. If you have received treatment in the past for the same or similar symptoms, who did you see? ☐ This Office ☐ Medical Doctor ☐Other ☐ Other Chiropractor ☐Physical Therapist

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10. The problem is worse with: ☐ coughing ☐ sneezing ☐ straining ☐ sleeping ☐ lifting ☐ rest ☐ activity ☐ weather changes ☐ sitting ☐ standing ☐ other _____

11. The problem is better with: ☐ medication ☐ rest ☐ activity ☐ stretching ☐ other _____ ☐ adjustments ☐ ice ☐ heat

12. What household, social, recreational, or work activities are now difficult or impossible to do because of your problem?

_____

_____

_____

13. 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 _____		

14. Do you have any previous fractures, dislocations, spinal injuries, surgeries, serious injuries, or illnesses not listed above?
☐ No ☐ Yes, please explain:

_____

_____

15. Do you use tobacco? ☐ No ☐ Yes, how much: _____ **Do you use alcohol?** ☐ No ☐ Yes, how much: _____
Do you use caffeine? ☐ No ☐ Yes, how much: _____

16. Do you take any medications or vitamins: ☐ Yes ☐ No
a. If yes, please list: _____

_____

17. Do you exercise regularly? How often and how long? _____

18. What is your occupation? ☐ Professional/Executive ☐ Laborer ☐ Retired ☐ White Collar/Secretarial ☐ Homemaker ☐Other: _____ ☐ Tradesperson ☐ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status:
☐ Full-time ☐ Part-time ☐ Self-employed ☐ Off work ☐ Unemployed ☐ Other

19. Were you referred by: ☐ Medical Doctor; name_____ ☐ Another Patient; name: _____

☐ Other; please explain: _____

Patient Signature: _____ **Date:** _____
(or legal guardian)

Insurance Information Form

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

Address: _____
Street 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:** _____
☐ Send me a monthly newsletter!

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

Employers Name: _____ **Work phone number: (_____)**_____

Emergency Contact: _____
Last First Phone number

Do you have Health Insurance? ☐ **No** (skip to section C) ☐ **Yes** (Fill out Section A and C)
☐ I have more than one Health Insurance (Fill out Section A, B, and C)

Primary 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:** _____

Secondary 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.

I will be paying by: ☐ Check ☐ Cash ☐ Credit Card ☐ Other

Signature: _____ **Date:** _____

Office use only
___ Verify Insurance ____ Entered into Computer ___ Copy Sent to Billing Company