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.***

Children's Health Review

Montrose Family Chiropractic Clinic
145 Nelson Blvd Ste 1000
PO Box 406
Montrose, MN 55363

Patient's Name _____ **Date** _____

Parents' (Legal Guardians') Names: _____ _____
Mother's Name Father's Name

Family Doctor/Pediatrician's Name: _____

Date of last visit: _____ Reason: _____

How was your child referred to Montrose Chiropractic Clinic? _____

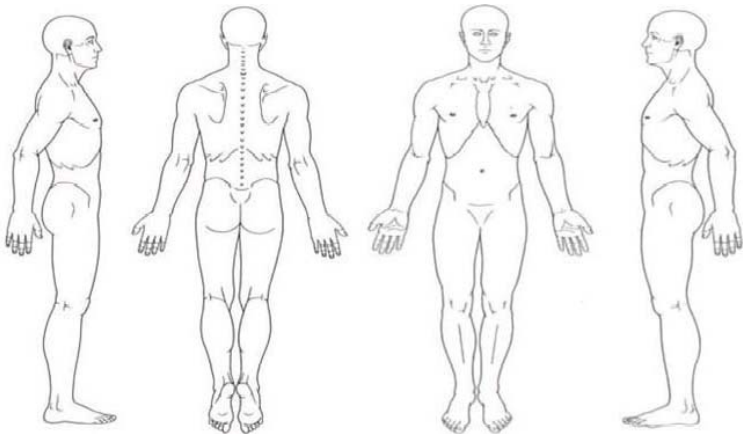
Has your child seen another Chiropractor before? ☐ Yes ☐ No
If so, when: _____ For what Condition: _____

Please describe the problem that brings your child to our office: _____

_____

_____

Please indicate the problem areas on the diagram:



Has the child ever had similar symptoms in the past?
☐ Yes ☐ No

When did the problem begin? _____

What caused the pain or trouble? _____

_____

_____

How are the symptoms changing?
☐ getting better ☐ not changing ☐ getting worse

What makes the pain/trouble worse? _____

What makes the pain/trouble better? _____

How often does the child experience the 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)

Describe any treatments they have received for this problem: _____

_____

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1.) Date of last general physical examination: _____ □ never had one

2.) Date of last spinal examination: _____ □ never had one

3.) Does your child take vitamin supplements? □ No □ Yes, please list: _____

4.) Does your child take any medications? □ No □ Yes, please list: _____

5.) Were there any complications at birth? □ No □ Yes, please list: _____
Was the forceps necessary? □ No □ Yes
Was the use of any medication necessary for the mother? □ No □ Yes

6.) Is there any indication of visual problems? □ No □ Yes

7.) Is there any indication of hearing problems? □ No □ Yes

8.) Any variance from normal developmental? □ No □ Yes

9.) Did this child ever use a walker or Johny-jump-up? □ No □ Yes, for how long? _____

10.) Have there ever been any known injuries? □ No □ Yes, please list: _____

11.) Is/was your child breast fed? □ No □ Yes

12.) Are/were there any dietary problems? □ No □ Yes, please list: _____

13.) Does your child eat a lot of sweets, food with
Coloring, junk food, or processed food? □ No □ Yes
How much water do they consume in a day? _____

14.) Is there any indication of food (or other) allergies? □ No □ Yes, please list: _____

15.) Is there any indicaton of ongoing constipation or
Diarrhea or other digestive complaints? □ No □ Yes, please describe: _____

16.) Does your child sleep poorly? □ No □ Yes, please describe: _____

17.) Is there any problem with enuresis (bed wetting)? □ No □ Yes
Is your child continent through the day? □ No □ Yes

18.) If in school, is there any problem with:
Attention span? □ No □ Yes
Physical coordination? □ No □ Yes
Sitting still? □ No □ Yes
Interaction with other children? □ No □ Yes

19.) What does your child prefer to be: □ active (i.e. sports, games) □ inactive (i.e. reading, puzzles?)

20.) Is there any indication of ongoing or frequent colds, ear infections, asthma, or bronchitis? □ No □ Yes

21.) Is there any complaint of spinal problems? □ No □ Yes, please describe: _____

22.) Is there any complaint of joint problems? □ No □ Yes, please describe: _____

23.) Does your child have brothers and sisters? □ No □ Yes, please list: _____

24.) Do any of your child's siblings have any health problems? □ No □ Yes, please list: _____

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

Insurance Information Form

Montrose Family Chiropractic Clinic
145 Nelson Blvd Ste 1000
PO Box 406 Montrose, MN 55363

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