Cornerstone CHIROPRACTIC

804 N. 16th Street, Montevideo, MN 56265 Ph. 320.269.3211

Name: ___________________________ *DOB:* ________________ *Date:* _____________

Auto / Personal Injury Patient Case History

Please complete this questionnaire as thoroughly as possible so we can learn about your health and better help you.

Address ______________________________ City _______________ State ______ Zip _________
Home Phone _______________ Work Phone _______________ Cell Phone _________________
E-mail Address ____________________________________ **Gender**: □ Male □ Female

Preference for Appointment Reminders & Other General Contact: □Phone □Email □Text (Cell Company:_________)

Preferred Language: □ English □ Spanish □ Other: ____________________
Race & Ethnicity: □ White □ Hispanic or Latino □ Black or African American □ American Indian or Alaska Native □ Asian □ Native Hawaiian or Pacific Islander □ Other or Decline to answer

Social Security Number ____________________
Marital Status □ M □ S □ D □ W Spouse's Name ________________________________
Children's Names & Ages ____
Who referred you to us? ____
How else did you hear about us? ______________________________________

ACCIDENT DETAILS

1. Date : _____________ State: ______Time _______ am / pm Driver of vehicle ____________________
2. Where were you seated? □ Driver's seat □ Front right passenger □ Front center passenger
   □ Rear left passenger □ Rear right passenger □ Rear center passenger
3. Who owns the car? ____
4. Description of other vehicle involved in accident ____________________________
5. What was the damage done to the car you were in? □ Mild □ Moderate □ Severe □ Total □ Unknown
6. Visibility at the time of the accident was: □ Poor □ Fair □ Good
7. The road conditions at the time of the accident were: □ Snow/Icy □ Wet □ Clear □ Dark
8. Type of accident: □ Was hit in the… □ Rear □ Right side □ Left side □ Front
   □ Hit another car in the…□ Rear □ Right side □ Left side □ Front
9. If this was not a collision, please describe: ______________________________
10. Were you aware the accident was about to happen? □ Yes □ No
11. Did you brace for the impact? □ Yes □ No
12. Were you wearing a seat belt? □ Yes □ No Shoulder harness? □ Yes □ No
13. Did the car you were in have a headrest? □ Yes □ No
    If yes, what was the position of the headrest compared to your head *before* the accident?
    □ Top of headrest even with bottom of the head
    □ Top of headrest even with top of head
    □ Top of headrest even with middle of neck
14. Was the car equipped with an airbag where you were seated? □ Yes □ No
    If yes, did the airbag inflate? □ Yes □ No
    Were you injured by the inflating airbag? □ Yes □ No
    If yes, what were your injuries? ______________________________________
15. Was your car braking? □ Yes □ No
16. Was your car moving at the time of the accident? □ Yes □ No
    If yes, how fast would you estimate you were going? ______________ MPH (estimate)
17. How fast would you estimate the other car was going? _______________ MPH (estimate) □ Don't know
18. Describe in your own words what happened to you upon impact: ________________________

____
19. Head and body position at the time of impact was:
    □ Head turned… □ Right □ Left □ Head straight forward □ Head looking back
    □ Body rotated… □ Right □ Left □ Body straight in sitting position
20. At the time of the accident, what parts of your head or body hit what parts on the inside of your car?

____
21. As a result of the accident, you were: □ Rendered unconscious □ Dazed, circumstances vague
    □ Shaken up but could think clearly and function

Name: ___________________________ DOB: ________________ Date: _____________

22. Could you move all parts of your body? □ Yes □ No
    If no, what body parts could you not move, and why not? ____________________________
23. Were you able to get out of the car and walk unaided? □ Yes □ No
    If no, why not? ____
24. Did you receive any medical assistance at the scene of the accident? □ Yes □ No

Illustrate below how the accident happened:

SYMPTOMS FROM ACCIDENT

1. Did you get any bleeding cuts? □ Yes □ No If yes, where? ______________________________
2. Did you get any bruises? □ Yes □ No If yes, where? ____________________________________
3. Please describe how you felt:
   Immediately after the accident ____
   Later that day ____
   The next days ____
4. Check symptoms apparent **since** the accident:

□ Headache	□ Neck pain/ stiffness	□ Mid-back pain	□ Low-back pain
□ Eyes light sensitive	□ Pain behind eyes	□ Dizziness	□ Fainting
□ Sleeping problems	□ Fatigue	□ Loss of smell	□ Loss of taste
□ Numbness in fingers	□ Numbness in toes	□ Loss of memory	□ Loss of balance
□ Shortness of breath	□ Ringing/ buzzing	□ Irritability	□ Depression
□ Cold hands	□ Cold feet	□ Diarrhea	□ Constipation
□ Tension	□ Nervousness	□ Anxiety	□ Cold sweats
□ Chest pain	□ Facial pain	□ Clicking or popping jaw	

   □ Other ____

5. Describe your primary complaints, name the body parts: ___________________________
____

   a. How often does it affect you? □constant □intermittent
   b. Symptom is currently: □increasing □decreasing □not changing
   c. Symptom is worse in the: □morning □afternoon □night □same all day
   d. If there is pain, is it: □sharp □dull □ache □shooting □tingling □radiating □stabbing □other_________

***PAIN LEVEL**: On a scale of 0 - 10, with 0 being pain free and can function quite well, and 10 being excruciating pain all the time, where would you rate the intensity of your pain?*

|______________________________________|
0 1 2 3 4 5 6 7 8 9 10
No Pain — Low Pain — Moderate Pain — Intense Pain — Excruciating Pain

   e. What is your ability to perform the following activities? U=unable, P=painful, L=limited, N=normal

_____ Coughing or sneezing	_____ Climbing	_____ Kneeling
_____ Getting in or out of car	_____ Balancing	_____ Looking back
_____ Putting on clothes	_____ Putting on shoes	_____ Stooping
_____ Turning over in bed	_____ Getting out of bed	_____ Pushing
_____ Lying flat on stomach	_____ Gripping	_____ Pulling
_____ Lying on side with knees bent	_____ Reaching	

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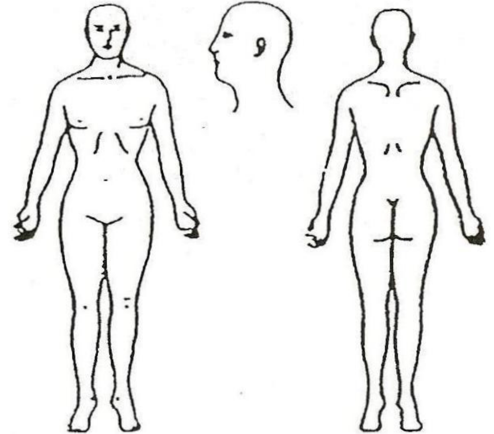
f. What makes the symptom better? □nothing □sitting □lying down □walking □moving □bending/twisting □other____

g. What makes the symptom worse? □nothing □sitting □lying down □walking □moving □bending/twisting □other____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles ·••• Stabbing ////



WORK STATUS HISTORY

Occupation: ______________________________________

Employer: ____________________________

Have you missed time from work? □ Yes □ No

If yes, were you unable to work since the accident? □ Yes □ No
If yes, full time off work from ___________ to ___________
If yes, part time off work from ___________ to ___________

INJURY TREATMENT

1. Have you treated your symptoms at home? □ice □heat □medication □other_____________

2. Did you seek medical help immediately after the accident? □ Yes □ No

If yes, what hospital/clinic did you go to? ____
If yes, how did you get there? □ Ambulance □ Police □ Someone else drove me □ Drove myself □ Other __________________________
Were you hospitalized as a result of this accident? □ Yes □ No

Doctor 1: Name_______________________________________ Date of first visit_________________

Were you examined? □ Yes □ No Were X-rays taken? □ Yes □ No
Did you receive treatment? □ Yes □ No
If yes, what kind of treatment did you receive? ____
What benefits did you receive from the treatment? ____
Date of last treatment ________________________

Doctor 2: Name_______________________________________ Date of first visit_________________

Were you examined? □ Yes □ No Were X-rays taken? □ Yes □ No
Did you receive treatment? □ Yes □ No
If yes, what kind of treatment did you receive? ____
What benefits did you receive from the treatment? ____
Date of last treatment ________________________

PRIOR SIMILAR SYMPTOMS

1. Did you have any physical complaints **just before this accident**? □ Yes □ No
If yes, please describe any physical complaints **just before this accident**: _________________________
____

2. Have you EVER had any PRIOR injuries, accidents, diseases, or treatment to the area of your body now affected? □ Yes □ No
If yes, state what part of your body was previously injured and describe the injury:
____
Were you treated? □ Yes □ No If yes, who treated you? _____________________________________
What date did the treatment begin? _______________ When did the treatment end? ________________
When was the last time (date) that you felt pain or problems from that injury? ___________________

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HEALTH HISTORY

1. Have you suffered injuries in the past? □yes □no

   □ car accident date______ □ falls date______ □ hospitalization date______

   □ fracture date______ □ sprain/strain date______ □ other__________________

2. Do you have a family history of:

   □ heart disease □ cancer □ arthritis □ diabetes □ lung conditions □ high blood pressure

   □ stroke/vascular problems □ kidney or liver conditions □ other_____________

3. Do you have a family physician? Name: ____

4. **Please list any disease or condition with which you have been diagnosed:** _______________
   ____ □ *No Diagnoses*

5. Please list any nutritional supplements that you are currently taking: ____________________
   ____ □ *No Supplements*

6. **Please list any medications that you are currently taking:** ____________________________
   ____ □ *No Medications*

7. **Please list any medication allergies that you have:** ___________________________________
   ____ □ *No Known Med. Allergies*

8. Please list any surgical operations and dates ____
   ____ □ *No Surgeries*

9. **Current Height:** _________________ **Current Weight:** _________________

10. **Smoking status (age 13 & over)**: □ Never smoked □ Former smoker □ Current smoker

Neck Disability Questionnaire

Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that 2 of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

Pain Intensity

[ ] I have no pain at the moment.
[ ] The pain is mild at the moment.
[ ] The pain is comes and goes and is moderate.
[ ] The pain is moderate and does not vary much.
[ ] The pain is severe but comes and goes.
[ ] The pain is severe and does not vary much.

Personal Care (e.g., Washing, Dressing)

[ ] I can look after myself normally without causing increased pain.
[ ] I can look after myself normally, but it increases my pain.
[ ] It is painful to take care of myself, and I am slow and careful.
[ ] I need help, but I am able to manage most of my personal care.
[ ] I need help every day in most aspects of my care.
[ ] I do not get dressed, I wash with difficulty, and stay in bed.

Work

[ ] I can do as much work as I want to.
[ ] I can only do my usual work, but no more.
[ ] I can do most of my usual work, but no more.
[ ] I cannot do my usual work.
[ ] I can hardly do any work at all.
[ ] I cannot do any work at all.

Driving

[ ] I can drive my car without neck pain.
[ ] I can drive my car as long as I want with slight pain in my neck.
[ ] I can drive my car as long as I want with moderate pain in my neck.
[ ] I cannot drive my car as long as I want because of moderate pain in my neck.
[ ] I can hardly drive my car at all because of severe pain in my neck.
[ ] I cannot drive my car at all.

Headaches

[ ] I have no headaches at all.
[ ] I have slight headaches which come infrequently.
[ ] I have moderate headaches which come infrequently.
[ ] I have slight headaches which come frequently.
[ ] I have moderate headaches which come frequently.
[ ] I have headaches almost all the time.

Concentration

[ ] I can concentrate fully when I want to with no difficulty.
[ ] I can concentrate fully when I want to with slight difficulty.
[ ] I have a fair degree of difficulty in concentrating when I want to.
[ ] I have a lot of difficulty in concentrating when I want to.
[ ] I have a great deal of difficulty in concentrating when I want to.
[ ] I cannot concentrate at all.

Sleeping

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

Reading

[ ] I can read as much as I want to with no pain in my neck.
[ ] I can read as much as I want with slight pain in my neck.
[ ] I can read as much as I want with moderate pain in my neck.
[ ] I cannot read as much as I want because of moderate pain in my neck.
[ ] I cannot read as much as I want because of severe pain in my neck.
[ ] I cannot read at all.

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Recreation

- [ ] I am able to engage in all recreational activities with no pain in my neck at all.
- [ ] I am able to engage in all recreational activities with some pain in my neck.
- [ ] I am able to engage in most, but not all recreational activities because of pain in my neck.
- [ ] I am able to engage in a few of my usual recreational activities because of pain in my neck.
- [ ] I can hardly do any recreational activities because of pain in my neck.
- [ ] I cannot do any recreational activities at all.

Lifting

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

Review of Systems

Past	Present	
☐	☐	Neck or back pain
☐	☐	Headaches
☐	☐	Jaw pain
☐	☐	Arm, shoulder, elbow, wrist or hand pain
☐	☐	Leg, hip, knee, ankle or foot pain
☐	☐	Swelling or stiffness of joints
☐	☐	Numbness, loss of sensation, or tingling
☐	☐	General fatigue
☐	☐	Depression
☐	☐	Troubled sleep
☐	☐	Loss of memory
☐	☐	Fainting
☐	☐	Seizures
☐	☐	Visual disturbances
☐	☐	Dizziness
☐	☐	Ear noises or ringing
☐	☐	Hard of Hearing
☐	☐	Earache or Ear Fluid
☐	☐	Shortness of breath or wheezing
☐	☐	Chronic cough or chronic sinusitis
☐	☐	Runny nose or post nasal drip
☐	☐	Throat soreness or hoarseness
☐	☐	Chronic ear or throat infections
☐	☐	Loss of taste or appetite
☐	☐	Abnormal weight gain or loss
☐	☐	Excessive thirst
☐	☐	Heat or cold intolerance
☐	☐	Loss of bladder control
☐	☐	Painful or frequent urination
☐	☐	Bladder infection
☐	☐	Kidney disorder or stones
☐	☐	Abdominal pain
☐	☐	Constipation/irregular bowel habits
☐	☐	Liver or gallbladder problems
☐	☐	Hernia
☐	☐	Irritable bowel or colitis
☐	☐	Nausea
☐	☐	Bloating or gas
☐	☐	Diarrhea

Past	Present	
☐	☐	Hemorrhoids
☐	☐	Difficulty swallowing
☐	☐	Heartburn or indigestion
☐	☐	Ulcer
☐	☐	Aortic aneurysm
☐	☐	High blood pressure
☐	☐	Heart murmur
☐	☐	Heart palpitations
☐	☐	Chest pains or angina
☐	☐	Heart attack
☐	☐	Stroke
☐	☐	Asthma or Allergies
☐	☐	Skin rashes
☐	☐	Cancer or non-cancerous tumor
☐	☐	Blood disorder
☐	☐	Emphysema
☐	☐	Arthritis (or Rheumatoid arthritis)
☐	☐	Diabetes
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Lupus
☐	☐	HIV/AIDS
☐	☐	Other______________________
Men Only		
☐	☐	Prostate problems
☐	☐	Erectile dysfunction
☐	☐	Testicular pain
Women Only		
☐	☐	Irregular menstrual flow
☐	☐	Breast soreness or lumps
☐	☐	Menstrual cramping
☐	☐	PMS
☐	☐	Endometriosis
☐	☐	Recurrent yeast or fungal infection
☐	☐	Hot flashes

Duration of cycle _______ Duration of flow ________
Menstrual flow: ☐ Heavy ☐ Moderate ☐ Light
Last period _____________
No. Pregnancies _________ No. Births ___________
Contraception Type _________________________

Patient's signature: ____ **Date:** ______________________
Parent/ Guardian signature: ____ **Date:** ______________________

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AUTOMOBILE INSURANCE INFORMATION

Insurance Company Name ____________________________ Policy # _____________________________

Accident Claim # _____________________________ *Verified By:* ________________________ (Office Use Only)

Claims Address: ____

Agent's Name _______________________________________ Phone # ______________________

Adjuster's Name _____________________________________ Phone # ______________________

HEALTH INSURANCE INFORMATION

Insurance Company Name ___________________________ Policy # ______________________________

Group # _______________________Policyholder Name __________________________________

LEGAL INFORMATION

Do you have an attorney on this case? □ Yes □ No If yes, whom? ______________________________

Note: Patients involved in litigation (lawsuits) or third party payment are ultimately responsible for payment of services.

OFFICE FINANCIAL POLICY

All claims will first be submitted to your insurance company and, following receipt of benefits, a statement of your responsibility will be sent to you. In order to avoid accumulating an unmanageable balance, individual accounts are not allowed to exceed $200 and family accounts cannot surpass $300. Chiropractic care will not be rendered if balances exceed these amounts. We welcome periodic payments while we wait to hear back from your insurance company in order to keep your account balance manageable.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

****

Your signature on this intake form denotes that you understand the above policies and agree to abide by the same. You understand that you are ultimately responsible for all charges whether or not covered by the automobile insurance claim. For your convenience, we accept cash, check, Visa and MasterCard. Your signature below authorizes the doctor(s) to release all information necessary to secure the payment of benefits from your automobile insurance carrier. In addition, your signature authorizes the use of your signature here on all claim submissions.

________________________________ ________________________________

Patient or Legal Guardian Signature Relationship or authority if not signed by patient

________________________________ ________________________________

Date Cornerstone Chiropractic Staff

<< 99201: 1-4 elem. // 99202: 6 elem. // 99203: 12 elem. // 99211: 5 min. // 99212: 1-5 elem. // 99213: 6 elem. // 99214: 12 elem. >>