KLUSENDORF CHIROPRACTIC, SC

2505 E. Evergreen Dr., Suite A
Appleton, WI 54913

Please Print: EHR - 1

Date: _____ Chart Number: _____

Name: First_____ Middle_____ Last_____

Date of Birth: _____/_____/_____ Gender: Male Female Soc Sec #:_____

Address 1:_____ Address 2:_____

City: _____ State: _____ Zip: _____

Home phone: _____ Wk Phone: _____ (May we call you here? Yes No)

Cell phone: _____ Cell Carrier: _____ (Ex: Verizon, Sprint, etc)

Email address: _____

What is the best way to contact you: Home Phone____ Cell Phone____ Work Phone____ Email ____

Occupation:
Employer:
Employer's Address:
Phone: May we call you at work? Y N

Marital Status: S M D W Spouse's name: _____

Children: _____

Spouse's Employer:
Address:
Phone: May we call them at work? Y N

If Patient is a minor:

Mother's Name: _____

Address (if different) _____

Phone number (if different): (_____)_____

Father's Name: _____

Address (if different) _____

Phone number (if different): (_____)_____

Name of person responsible for billing: _____

KLUSENDORF CHIROPRACTIC, SC

Patient Name: _____ Date: _____ Chart #: _____

Primary Insurance: _____ Secondary Insurance: _____

(Please provide your insurance card(s) to receptionist)

If you are NOT the policy holder for the insurance please complete the following:

Name of Insurance Company:
Full Name of Policy Holder:
Birth Date of Policy Holder:
Address of Policy Holder:
Patient's relationship to policyholder:

Preferred Language:_____

Smoking Status: [ ] Current every day smoker [ ] Current some day smoker
[ ] Former smoker [ ] Never smoker

Race: [ ] White [ ] American Indian or Alaskan Native [ ] African American
[ ] Asian [ ] Native Hawaiian or Pacific Islander [ ] Prefer Not to Answer

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Prefer Not to Answer

Name of Primary Care Doctor:	Clinic Name:
Dr.'s Address:	City/State:
Dr.'s Phone number:	

Who may we thank for referring you to our office? _____

Is this due to an accident at work, home or auto? [ ] Yes [ ] No [ ] Other: _____

* * * * * * * * * * * *

I hereby give permission to Dr. Klusendorf and/or his representative to release any information acquired in the course of my examination and treatment to my insurance company, if requested.

I hereby authorize and direct my insurance benefits to be paid directly to KLUSENDORF CHIROPRACTIC, SC. I acknowledge that ***I am financially responsible*** **for** ***any non-covered services.***

I hereby give permission to Dr. Klusendorf and/or his associates to administer treatment and perform such general procedures as may be deemed necessary in the diagnosis and/or treatment of my condition.

Signature: _____ Date: _____
(Patient or parent/legal guardian)

KLUSENDORF CHIROPRACTIC, SC

Patient Name: _____ Date: _____ Chart #: _____

Please list medications you are **currently** taking and dosages:

_____ _____ _____

_____ _____ _____

Please list medications you are **allergic** to and **your reaction***:*

_____ _____ _____

_____ _____ _____

Briefly Describe your Family Health History (Example: Heart Disease/Stroke/Cancer)

Mother	Father
Siblings	Siblings

Accidents and/or Injuries:

Type: _____ When: _____ Hospitalized: [ ] Y [ ] N

Type: _____ When: _____ Hospitalized: [ ] Y [ ] N

Type: _____ When: _____ Hospitalized: [ ] Y [ ] N

Type: _____ When: _____ Hospitalized: [ ] Y [ ] N

List your problems or complaints according to severity of pain.	Date started or for how long?	If you've had the condition before, when?	Did the problem begin with an injury?

What is your use of the following?	None	Light	Moderate	Heavy
Tobacco Products				
Alcohol				
Soft Drinks				
Salt				
Sugar				

Height: _____ Weight: _____ Blood Pressure: _____/_____

KLUSENDORF CHIROPRACTIC, SC

Patient Name: _____ Date: _____ Chart #: _____

Allergies

____Animals ____Codeine ____Morphine ____Soaps

____Dairy Products ____Aspirin/Pain Meds ____Bee Stings ____Latex

____Mold ____Penicillin ____Eggs ____Rubber

____Seasonal Allergies ____Iodine ____Dust ____Shellfish

____X-ray Dye ____Sulfa ____Ragweed/Pollen ____None

____Other_____

Surgeries

____Appendix ____Hip Replacement ____Obstetrical ____Lumbar Disc

____Carpal Tunnel R L ____Knee Replacement ____Prostate ____Thoracic Disc

____Foot ____Shoulder R L ____Brain ____Cervical Disc

____Elbow ____Back ____Gallbladder ____Hernia

____Gastrointestinal ____EENT ____Wisdom teeth ____None

____Heart ____Gynecological ____Other_____

Medical History

____Ankle pain ____Arm pain ____Arthritis ____Asthma

____Back pain ____Broken bones ____Cancer ____Chest pain

____Depression/Other ____Diabetes ____Dizziness ____Elbow/wrist pain

____Epilepsy ____Eye/vision problems ____Fainting ____Fatigue

____Foot pain ____Genetic spinal disorder ____Hand pain ____Headaches

____Hearing Problems ____Hepatitis ____High blood pressure ____Hip pain

____Jaw pain ____Joint stiffness ____Knee pain ____Leg pain

____Low back pain ____Menstrual problems ____Mid back pain ____Pacemaker

____Multiple Sclerosis ____Neck pain ____Neurological disorder ____Stroke/Heart attack

____Parkinson's Disease ____Polio ____Prostate problems ____Use CPAP

____Significant weight change ____Spinal cord inj. ____Sprain/strain ____None

____Stomach problems ____Tumor ____Ulcer(s)

____Other_____

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AUTO ACCIDENT

Please Print

First Name: _____ Middle: _____ Last: _____

Date of Accident: _____ Time of Accident: _____
Accident Type: [ ] Head on [ ] Broad Side [ ] Rear-end [ ] Front impact (rear-ended car in front)
[ ] Non-collision (describe): _____
_____

Visibility at time of accident: [ ] Poor [ ] Fair [ ] Good [ ] Other: _____

Road conditions at the time of accident: [ ] Icy [ ] Rainy [ ] Wet [ ] Clear [ ] Dark
[ ] Other: _____

Where were you seated? [ ] Front-driver side [ ] Front-center [ ] Front-passenger side
[ ] Back-driver side [ ] Back-center [ ] Back-passenger side

Where was your car struck? [ ] Right [ ] Left [ ] Rear [ ] Front [ ] Side
[ ] Other: _____

Did you see the accident coming? [ ] Yes [ ] No Did you brace for impact? [ ] Yes [ ] No

Was your car braking? [ ] Yes [ ] No

Were seat belts worn? [ ] Yes [ ] No Were shoulder harnesses worn? [ ] Yes [ ] No

Does your car have headrests? [ ] Yes [ ] No
If yes, what was the position of those headrests compared to your head before the accident?
[ ] Top of headrest even with **bottom** of head [ ] Top of headrest even with **top** of head
[ ] Top of headrest even with **middle of neck**

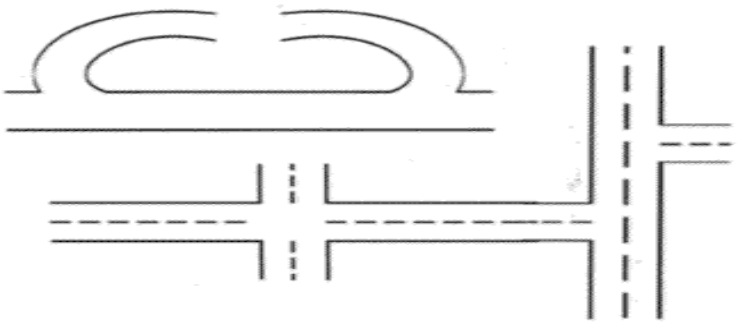
Was your car moving at the time of the accident? [ ] Yes [ ] No
If yes, estimate your speed: _____

How fast was the other car traveling? Estimate their speed: _____
_____

Explain WHEN and HOW the accident happened: _____
_____
_____
_____
_____

Describe in your own words what happened to you upon impact: _____
_____
_____

**Use diagram to show the accident. Show direction of travel with arrows. Mark traffic signals, signs, pedestrian cross walks and any other distinguishing marks. Draw your own diagram if the one provided does not work.*



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AUTO ACCIDENT

Name: _____

Head/body position at the time of impact: [ ] Head turned left/right [ ] Head looking back
[ ] Head straight forward [ ] Body straight in sitting position
[ ] Body rotated left/right [ ] Other: _____
_____

At the point of impact, which parts of your body struck an object:
[ ] Head [ ] Face [ ] Chest [ ] Neck [ ] Back [ ] Right Shoulder [ ] Left Shoulder
[ ] R Arm [ ] L Arm [ ] R Leg [ ] L Leg [ ] R Knee [ ] L Knee

Select the objects that your body struck:
[ ] Windshield [ ] Headrest [ ] Dashboard [ ] Steering Column [ ] Door Frame
[ ] Back of Seat [ ] Rear View Mirror

As a result of the accident you were: [ ] Rendered unconscious [ ] Dazed, circumstances vague
[ ] Other (please describe): _____

Could you move all parts of your body? [ ] Yes [ ] No
If no, why not: _____

Were you able to get out of the car and walk unaided? [ ] Yes [ ] No
If no, why not: _____

Did you get bruises or bleeding cuts? [ ] Yes [ ] No
If yes, describe: _____
_____

The symptoms: [ ] Come and go [ ] Came on gradually [ ] Came on suddenly

The symptoms have persisted for: [ ] Hours [ ] One day [ ] Days [ ] Weeks [ ] Months [ ] Years

The symptoms are BETTER in: [ ] AM [ ] Midday [ ] PM

The symptoms are WORSE in: [ ] AM [ ] Midday [ ] PM [ ] They do not change with time of day

List complaints in order of severity of pain:	Date started or how long?	If you've had this condition before, when?	Did the problem begin with an injury?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

What activities make condition **WORSE:** _____

What activities make condition **BETTER:** _____

Please describe how you felt (be specific)
Immediately after the accident: _____
Later that day/night: _____
The next day: _____

Indicate any action take immediately following the accident:
[ ] Went home and took it easy [ ] Went about normal business [ ] Went to physician
[ ] Went to hospital [ ] Went to work [ ] Doctored myself, thinking pain would go away

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AUTO ACCIDENT

Name: _____

HOSPITALIZATION INFORMATION:
Indicate method of delivery to hospital:
[ ] Ambulance [ ] Patient drove self [ ] Driven by someone else [ ] Went home first, taken later

Name of Hospital: _____
Address: _____ City: _____ State: _____ Zip : _____

Were you seen in the emergency room: [ ] Yes [ ] No
Length of stay: _____

Name of admitting physician (if known): _____

Indicate any procedure performed at the hospital including those done in the emergency room.
[ ] Examination [ ] X-rays [ ] Prescription [ ] Injection [ ] Stitches [ ] Physiotherapy
[ ] Cervical Collar [ ] Wounds dressed [ ] Complete bed rest
[ ] Other: _____

PHYSICIAN INFORMATION:
Who was the first physician you consulted: _____
[ ] Family physician [ ] Chiropractor [ ] Orthopedist [ ] Osteopath [ ] Neurologist [ ] Walk-in clinic
[ ] Other: _____

If physiotherapy was rendered, were you sent out? [ ] Yes [ ] No
If yes, where were treatments received: _____

Did the doctor refer you to or have you been to any other physicians? [ ] Yes [ ] No
If yes, please explain: _____

How long were you under the care of your physician: _____
Are you still under your physician's care? [ ] Yes [ ] No
Indicate the frequency of your visits to the doctor: _____

Were you sent for an independent medical exam? [ ] Yes [ ] No
If **yes**, doctor's name: _____

What medications are you currently taking because of this accident? _____
_____

Please list any other pertinent information: _____
_____
_____
_____

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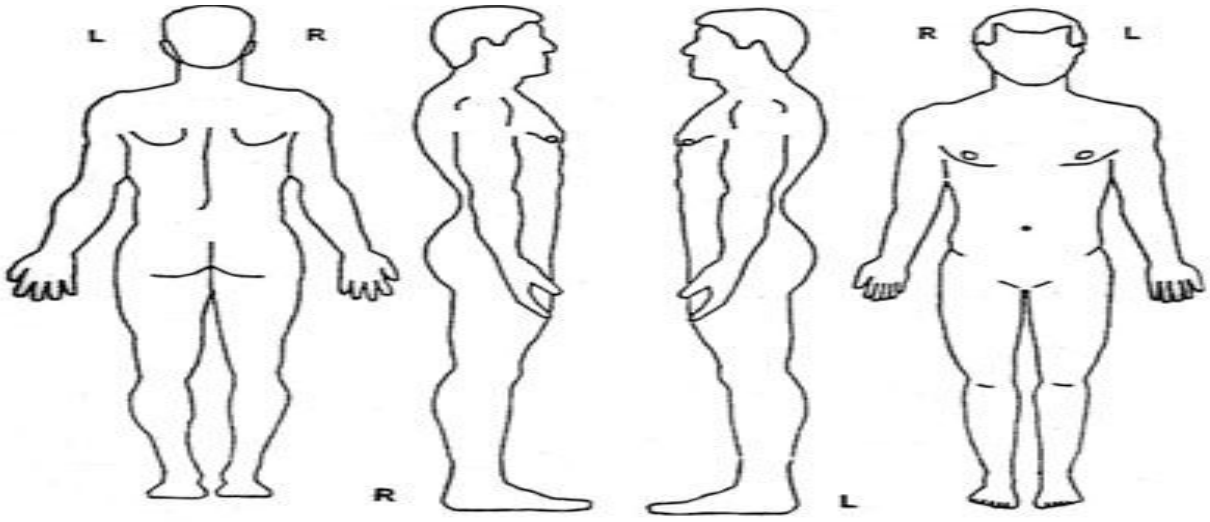
Name: _____ Date: _____

AUTO ACCIDENT

Please indicate areas of discomfort due to this accident using the symbols below.

Numbness	Pins & Needles	Burning	Aching	Stabbing
----------	0000000	^^^^^^	XXXX	……..

Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).



PI AUTO – INSURANCE INFORMATION FORM

Klusendorf Chiropractic, SC
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Personal Injury Case
File #: _____
Account #: _____

Please complete the entire form. We cannot process your claims if the information is not provided.

Please Print

Patient: _____ *First MI Last*	Driver's License #: _____
Owner of car: _____ *First MI Last*	Phone: (_____)_____
Driver of car: _____ *First MI Last*	Phone: (_____) _____
Date of accident: _____	

You are responsible for all charges on your account.
Our staff will do their best to process your claims and route them to the proper insurance companies and attorneys. You are to make progress payments on your account for an agreed upon amount beginning the first week of care. This amount will be determined during your consultation with the insurance specialist working on your claim. Please as for assistance if needed. THANK YOU!

YOUR AUTO INSURANCE COMPANY: _____
(Full name of company)
Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Claim #: _____

Adjuster: _____ Phone: (_____) _____

Do you have Med Pay on your policy? [ ] YES [ ] NO
Has your Med Pay limit been used? [ ] YES [ ] NO
Is your Med Pay contingent on your Health Insurance being billed first? [ ] YES [ ] NO
***If you are not sure about your Med Pay and Limits, please contact your insurance agent.**

NAME OF YOUR HEALTH INSURANCE COMPANY: _____
Address: _____ City: _____ State: _____ Zip: _____
Name of Insured: _____ Insured's Social Security #: _____
Insured's Date of Birth: _____ Group #: _____ Policy #: _____

IF ANOTHER CAR WAS INVOLVED IN THIS ACCIDENT:
Driver of car: _____ Insurance Company: _____
First MI Last
Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Claim #: _____

Adjuster: _____ Phone: (_____) _____

DO YOU HAVE AN ATTORNEY? [ ] YES [ ] NO

If yes, full name of attorney and/or name of Law Firm: _____

_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____