Great Lakes Chiropractic of St. Michael
116 Central Ave East St. Michael, MN 55376
PH: 763-515-6650 | FAX: 763-777-9186

PATIENT INFORMATION:

Date _____

Name _____

Email _____

Address _____ City _____State_____ Zip_____

Home Phone _____Work Phone _____ Cell Phone _____

Name of Spouse/Guardian _____ Spouse/Guardian Phone _____

Emergency Contact _____ Phone _____

Family Medical Doctor/Clinic_____

INSURANCE INFORMATION:

Motor Vehicle Insurance Company: _____

Adjuster's Name: _____

Adjuster's Phone Number: _____

Policy ID: _____

Claim #: _____

ACCIDENT INFORMATION:

1. Date of accident: _____/_____/_____

2. Time of accident: _____AM / PM

3. How many vehicles were involved in the accident? _____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occurred?

_____

8. What direction were you traveling in? Circle one.
North South East West

9. What type of impact was the auto accident? (Ex: rear ended / head on)

_____

10. Did your vehicle hit anything after the accident? If yes, please describe:

_____

11. Where were you sitting in the vehicle? Circle one.
Driving / Front passenger / Back seat on driver side / Back seat on passenger side

12. Did you know the accident was coming? Yes ___ No ___

13. What type of vehicle were you in? (Make/Model) _____

14. What type of vehicle impacted yours? (Make/Model) _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (Check all that apply)

___ kept going straight
___ kept going straight hitting a car in front
___ was hit by another vehicle
___ other: Details_____
___ spun around and hit a stationary object
___ hit a stationary object
___ spun around

18. Did you lose consciousness during the accident? Yes ___ No ___

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? No ___ Yes, please describe: _____

_____

23. Did your face hit anything during the accident? No ___ Yes, please describe_____

_____

24. Did your shoulders hit anything during the accident? No ___ Yes, please describe_____

_____

25. Did your neck hit anything during the accident? No ___ Yes, please describe: _____

_____

26. Did your chest hit anything during the accident? No ___ Yes, please describe: _____

_____

27. Did your hips hit anything during the accident? No ___ Yes, please describe: _____

_____

28. Did your knees hit anything during the accident? No ___ Yes, please describe: _____

_____

29. Did your feet hit anything during the accident? No ___ Yes, please describe: _____

_____

30. What kind of headrest was in your vehicle? (Circle one)
movable fixed headrest fixed non-movable headrest no headrest

31. Did you have your seatbelt on during the accident? Yes ___ No ___

32. Did you slide out of your seatbelt during the accident? Yes ___No ___

33. What was damaged in your vehicle? (Check all that apply)

___ windshield	___ rear bumper	___ mirror
___ steering wheel	___ front bumper	___ knee bolster
___ dashboard	___ trunk	___ back right door
___ rear window	___ front left door	___ back left door
___ side window	___ front right door	___ seat frame
___ entire vehicle totaled	___ other: _____	

34. Choose the items that dented inward:

___ floorboards ___ side door ___ dashboard ___ none

35. Choose the doors that would not open because of the accident:

___ front left ___ front right ___ rear left ___rear right

36. Did you go to the hospital? Yes ___ No ___

37. How did you get to the hospital? _____

38. What was the name of the hospital? _____

39. Were you hospitalized overnight? _____

40. What you were prescribed at the hospital?

___ pain medication ___ muscle relaxers ___ brace ___ other: _____

41. Please list any other medications you are taking with dose/frequency.

_____

_____

42. Did you receive any stitches for any cuts at the hospital? No ___ Yes ___ If yes, which area of the body?

_____

43. Were x-rays taken at the hospital? Yes ___ No___ If yes, which area of the body_____

44. Was an MRI or other study performed? Yes ___ No ___ If yes, which area of the body _____

45. Please list facility where images were taken, if applicable _____

INJURY INFORMATION:

46. What is injured from your accident/incident? _____

_____

47. Where does it hurt? Left? Right? Both sides? Other? _____

48. How would you describe your problem? Please circle all that apply.

Sharp	Shooting	Burning	Numb	Tingly
Dull	Achy	Sharp with Motion	Shooting with Motion	Stabbing with Motion

Other:_____

49. How often do you have this problem?

Constantly (75-100% of the time)	Frequently (50-75% of the time)	Occasionally (25-50% of the time)	Intermittently (Less than 25% of the time)

50. How would you rate the severity of your problem?

Mild	Moderate	Severe

51. Does your pain radiate anywhere in your body? If yes, please describe_____
_____

52. Do you have pain at night? If yes, please describe _____
_____

53. What makes your problem worse? Please circle all that apply.

Always there	Gardening	Shoveling	Standing up	Yard Work
Bending	Working Out	Sitting	Standing (long time)	Weather Changes
Driving	Lifting Objects	Sleeping	Stress	While at Work
Flexing/extending	Painting	Climbing Stairs	Computer Work	Sports:

Other, describe_____

54. What makes your problem better? Please circle all that apply.

Adjustments	Heat	Ibuprofen	Standing	Warm Bath
Bending Forward	Ice	Tylenol	Stretching	Nothing
Exercising	Massage	Rx Pain Medication	TENS/Muscle Stim	
Pain Relieving Cream	Muscle Relaxer	Resting	Walking	

55. Who have you seen for this problem? Please circle all that apply.

Chiropractor	ER Doctor	Massage Therapist	Physical Therapist
Neurologist	Orthopedist	Primary Care Doctor	No One

When and where? _____

For each of the conditions listed below, place a ✓ in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a ✓ in the "present" column.

PAST	PRESENT	SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT	SYMPTOM
		Headache			Rheumatoid Arthritis			Gallbladder disorder
		Neck pain			Cancer			Hepatitis
		Upper back pain			Benign tumor			Ulcer
		Mid back pain			Asthma			General fatigue
		Low back pain			Chronic Sinusitis			Visual disturbances
		Shoulder pain			High blood pressure			Dizziness
		Elbow/upper arm pain			Heart attack			Ringing in the ears
		Wrist pain			Chest pains			Diabetes
		Hip pain			Kidney stones			Frequent urination
		Upper leg pain			Kidney disorder			Drug dependence
		Knee pain			Bladder infection			Alcohol dependence
		Ankle/foot pain			Prostate problems			Depression
		Jaw pain			Weight gain/loss			Anxiety
		Joint pain/stiffness			Abdominal pain			Lupus
		Arthritis			Liver disorder			Epilepsy/seizures
		Loss of Sleep			Heartburn			Eczema/rash

Other_____

FAMILY HISTORY: (circle if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis	F	M	S	B	Cancer	F	M	S	B	Mental Illness	F	M	S	B
Diabetes	F	M	S	B	Asthma	F	M	S	B	Heart Disease	F	M	S	B
Arthritis	F	M	S	B	Kidney Disease	F	M	S	B	Lung Disease	F	M	S	B
Stroke	F	M	S	B	Liver Disease	F	M	S	B	Headaches	F	M	S	B
Low back pain	F	M	S	B	Neck Pain	F	M	S	B	Migraines	F	M	S	B

Other_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? **Yes** or **No** If yes, how much per week? _____

Have you ever used tobacco? **Yes** or **No** If yes, how much per day: _____

If a former tobacco user, date you quit _____

FEMALES ONLY: When was your last menstrual cycle? _____

Are you pregnant? No _____ Not Sure_____ Yes _____ Due Date: _____

Please ✓ if any of the following apply:

PAST	PRESENT	
		Birth control pill/patch, shot etc. Please specify:
		Hormone replacement: Describe
		Loss/termination of pregnancy:

Do you participate in any sports? Please circle all that apply.

Aerobics	Skiing	Basketball	Soccer	Baseball
Bicycling	Swimming	Football	Tennis	Golf
Lacrosse	Volleyball	Hockey	Walking	Softball
Running	Working Out	Martial Arts	Yoga/Pilates	Triathlons

Other_____

List any nutritional supplements you are taking (vitamins, herbs, naturopathic remedies, etc) _____
_____

Please list all surgical/hospitalizations you have had, including dates_____
_____
_____
_____

Do you have allergies of any kind? **Yes** or **No** If yes, describe: _____
_____

Have you had any PAST trauma (example: auto accident, work injury, broken bones/stitches)? Include dates:
_____
_____

Have you been treated for any health condition/any **other** health problems (no matter how insignificant they may seem be) by a physician in the last year? **Yes** or **No**

If yes, describe: _____

PATIENT'S SIGNATURE: _____ **DATE:** _____

GUARDIAN'S SIGNATURE AUTHORIZING CARE: _____ **DATE:** _____

DOCTOR'S SIGNATURE: _____ **DATE:** _____

AUTHORIZED PEOPLE WHO HAVE ACCESS TO MY INFORMATION

I authorize Great Lakes Chiropractic of St. Michael to share my account information including TREATMENT DETAILS, ACCOUNT INFORMATION, PAYMENT DETAILS, AND APPOINTMENT TIMES with the following people. (spouse, parent, children)

_____ _____
NAME RELATIONSHIP TO PATEINT

_____ _____
NAME RELATIONSHIP TO PATEINT

_____ _____
NAME RELATIONSHIP TO PATEINT

☐ **Please do NOT allow anyone to access my information**

This is valid until revoked or changed by written communication.

_____ _____
SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR) DATE