

# Prater View Chiropractic and Health Clinic

## PERSONAL HISTORY

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Date \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex:  Male  Female Social Security # \_\_\_\_\_

Age \_\_\_\_\_ Marital Status:  M  S  D  W  SEP. Occupation \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Contact Phone # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Have you seen a chiropractor before?  Yes  No

Approximately how long were your visits? \_\_\_\_\_

Was that too long or not long enough? \_\_\_\_\_

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## INJURY DETAILS

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ a.m./p.m.

Driver of car: \_\_\_\_\_ Where you were seated: \_\_\_\_\_

Owner of car: \_\_\_\_\_ Year and Model of car: \_\_\_\_\_

Visibility at time of accident:  Poor  Fair  Good  Other: \_\_\_\_\_

Road conditions at time of accident:  Icy  Rainy  Wet  Clear  Dark  Other: \_\_\_\_\_

Where was your car struck?  Right  Left  Rear  Front  Side  Other: \_\_\_\_\_

Type of accident:  head-on collision  broad-side collision  rear-end collision  front impact,  
 rear-ended car in front  non-collision  other: \_\_\_\_\_

What part of the car was damaged? \_\_\_\_\_

Describe what happened to you upon impact? \_\_\_\_\_

Did you see the accident was about to happen?  Yes  No

Did you brace for impact?  Yes  No

Were you wearing a seatbelt?  Yes  No

Were you wearing a shoulder harness?  Yes  No

Does the car have headrests?  Yes  No

If yes, what was the position of your headrest?  
 top of headrest even with bottom of head  
 top of headrest even with top of head  
 top of headrest even with middle of head

Was your car braking?  Yes  No

Was the other car braking?  Yes  No

Was your car moving at the time of the accident?  Yes  No If yes, how fast? (estimate) \_\_\_\_\_

What was the position of your head and body at the time of impact?  
 head turned left/right  body straight in sitting position  head looking back

body rotated left/right  head straight forward  other: \_\_\_\_\_

At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

As a result of the accident were you:  rendered unconscious  dazed  other: \_\_\_\_\_

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 have any cuts or bruises from this accident?  yes  no If so, where? \_\_\_\_\_

Describe how you felt immediately after the accident? \_\_\_\_\_

How did you feel later that  day  night? \_\_\_\_\_

How did you feel the next day(s)? \_\_\_\_\_

Check symptoms apparent since the accident:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> headache                | <input type="checkbox"/> loss of smell   | <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> neck pain/stiffness     |
| <input type="checkbox"/> loss of taste           | <input type="checkbox"/> cold hands      | <input type="checkbox"/> mid-back pain       | <input type="checkbox"/> loss of memory          |
| <input type="checkbox"/> cold feet               | <input type="checkbox"/> low-back pain   | <input type="checkbox"/> fatigue             | <input type="checkbox"/> diarrhea                |
| <input type="checkbox"/> tension                 | <input type="checkbox"/> constipation    | <input type="checkbox"/> pain behind eyes    | <input type="checkbox"/> shortness of breath     |
| <input type="checkbox"/> chest pain              | <input type="checkbox"/> dizziness       | <input type="checkbox"/> irritability        | <input type="checkbox"/> nervousness             |
| <input type="checkbox"/> fainting                | <input type="checkbox"/> depression      | <input type="checkbox"/> cold sweats         | <input type="checkbox"/> anxious                 |
| <input type="checkbox"/> sleeping problems       | <input type="checkbox"/> loss of balance | <input type="checkbox"/> numbness in toes    | <input type="checkbox"/> ringing/buzzing in ears |
| <input type="checkbox"/> eyes sensitive to light | <input type="checkbox"/> other: _____    |  |  |

Have you missed time from work?  Yes  No Work hours are:  Full-time  Part-time

If you have missed time from work, how much time have you missed? \_\_\_\_\_

Did the accident occur during your work hours?  yes  no

Did you seek medical help immediately/soon after the accident?  yes  no If yes, how did you get there? \_\_\_\_\_

Doctor/Hospital/Clinic seen: \_\_\_\_\_ Date: \_\_\_\_\_

Were x-rays taken?  yes  no If yes, of what body part? \_\_\_\_\_

What treatments/prescriptions were given?  bed rest  brace  adjustments  medications \_\_\_\_\_

What benefit(s) did you receive from treatment(s)? \_\_\_\_\_

Date of last treatment: \_\_\_\_\_

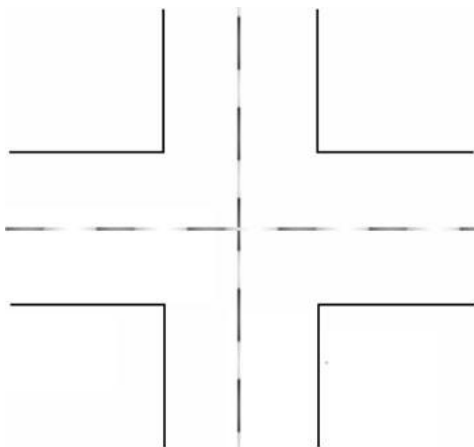
Are any of your activities of daily living any different now compared to before the accident?  yes  no

List anything you are unable to do: \_\_\_\_\_

List anything that is painful to do: \_\_\_\_\_

List anything that is difficult to do: \_\_\_\_\_

Indicate on the diagram below how the accident happened:



Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have an attorney handling this case?  Yes  No If yes, who? (Name/Address) \_\_\_\_\_  
\_\_\_\_\_

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## **INSURANCE INFORMATION**

Patient's personal insurance: \_\_\_\_\_  
Insured's name (if other than patient) \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone#: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Adjuster's name/phone: \_\_\_\_\_

Other party's insurance: \_\_\_\_\_  
Insured's name (if other than patient) \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone#: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Adjuster's name/phone: \_\_\_\_\_

Other insurance:  
Insured's name \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone#: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Adjuster's name/phone: \_\_\_\_\_

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## **CURRENT HEALTH CONDITION(S)**

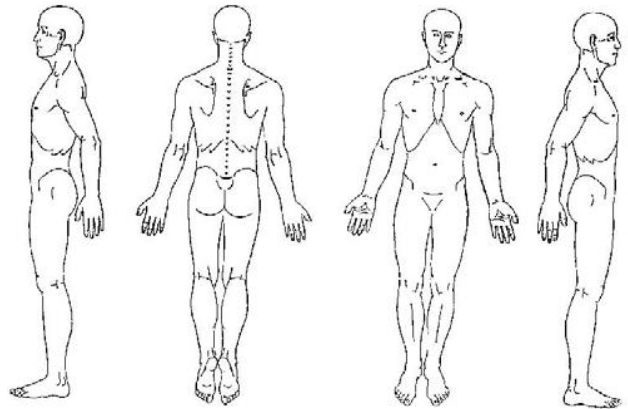
Using the adjacent body charts, please *circle* all affected areas.  
What are your current health condition(s)?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Have you been treated by another physician for this/these condition(s)?

Yes  No If so, please list other Doctors:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



LEFT

BACK

FRONT

RIGHT

On a scale of one to ten how intense are your symptoms? Not intense ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

Is your condition interfering with your:  Work  Sleep  Daily Routine? If so, how: \_\_\_\_\_  
\_\_\_\_\_

List all prescription, non prescription medications and other supplements you take as well as the associated condition: \_\_\_\_\_

List any surgeries or hospitalizations you have had complete with the month and year for each: \_\_\_\_\_

Do you have or have you had any diseases, medical conditions or procedures? \_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_

Please list anything that you may be allergic to: \_\_\_\_\_

Family Health History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual): \_\_\_\_\_

Previous X-rays taken?  Yes  No Areas: \_\_\_\_\_

Do you exercise?  Yes  No Hours per week \_\_\_\_\_ What activity(s)? \_\_\_\_\_  
Are you dieting?  Yes  No Since: \_\_\_\_\_ Do you drink alcoholic beverages?  Yes  No \_\_\_\_\_ drinks per day  
Do you smoke?  Yes  No \_\_\_\_\_ packs per day. How many years have you been smoking? \_\_\_\_\_  
Do you wear?  Heal lifts  Arch supports  Prescription Orthotics If so who recommended them? \_\_\_\_\_

For women:

Are you pregnant or nursing?  Yes  No If pregnant, how many weeks? \_\_\_\_\_  
Date of last menstrual period: \_\_\_\_\_

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## Prater View Chiropractic and Health Clinic

Darnell Simpson D.C.  
Devin Simpson D.C.  
118 S. Main St. Suite 400  
Thayne, WY 83127

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Phone: 307-883-7246  
Fax: 307-883-7247

### ***INFORMED CONSENT FOR CHIROPRACTIC CARE***

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by the doctor of chiropractic named above.

Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to you satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee for specific cure or result.

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Patient Signature

Date

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Parent or Guardian if patient is a minor

Date

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### ***Record Release and Assignment of Insurance Benefits***

The undersigned hereby authorizes the Release of any information relating to claims for benefits submitted. I further agree and acknowledge that I authorize my physician to submit claims for benefits, for services rendered, without obtaining my signature on each claim.

I (patient) \_\_\_\_\_ hereby authorize (Insurance Co.) \_\_\_\_\_  
\_\_\_\_\_ to pay and hereby assign directly to Dr. Darnell Simpson and/or Dr. Devin Simpson all owed benefits. I understand I am financially responsible for all charges incurred.

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Patient Signature

Date

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### Prater View Chiropractic and Health Clinic

118 S. Main St. Suite 400  
Thayne, WY 83127  
Phone: 307-883-7246

### ***OFFICE AND FINANCIAL POLICY***

#### **Insurance**

Prater View Chiropractic will file your insurance claim for you. We ask that you pay your co-pay, co-insurance and/or deductible at time of service. If payment is denied by your insurance company, you will be responsible for the amount not covered and a statement will be mailed to you. Your account may be assessed interest and/or late fees after 30 days.

**Private Pay Customers:** Payment in full is due at time of service for the discounted price. Payment arrangements must be made prior to appointment if you are unable to pay.

**Collections:** All accounts over 90 days past due or not in good standing will be turned over to our collection agency. Monthly payments must be made to keep your account current. Should collection become necessary, I/We agree to pay all attorney's fees, court costs, filing fees, and all collection costs up to 40% of the amount owing which may be assessed by any collection agency retained to pursue the matter. I/We further agree to pay a finance charge of 18% annual interest rate of the unpaid balance, or a minimum of \$1.50.

#### **Confidentiality**

Your records or information about your case cannot be shared without your prior written permission. Your records will not be released to anyone without written approval of the patient or the responsible party of a minor.

#### **Missed Appointments**

We require at least 24 hours notice if you need to change or cancel your appointment. If you fail to keep your appointment, **or do not provide us with 24 hours notice**, you will be charged a \$20.00 "broken appointment fee". Broken appointment fees must be paid prior to rescheduling your next appointment.

I have read the above statement and understand this office policy.

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Patient Signature

Date

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Parent or Guardian if patient is a minor

Date

### ***Assignment of Payment***

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Prater View Chiropractic and Health Clinic any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Prater View Chiropractic and Health Clinic the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Prater View Chiropractic and Health Clinic the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_