

WELCOME TO OUR OFFICE

You are the reason we are here! We are committed to earning your trust and confidence by giving you individualized and considerate healthcare. Dr. Knopp and staff always welcome comments and suggestions so that we can learn to serve you better.

*Please arrive on time so we can give you the entire time reserved for you.

*We require twenty-four hours notice to cancel your appointment. It is our policy to charge for no-shows or late cancellations. PLEASE NOTE: Our office will attempt to contact you to reschedule your missed appointment.

*Please respond promptly to the statements mailed to you. You may pay by cash, check or credit card. The fee is \$20.00 for each returned check. Delinquent accounts are transferred to a collection agency.

Health Insurance Plans require you to do the following things:

*Pay your co-payments and deductible to this office.

*Call your insurance company to understand your chiropractic benefits.

*Obtain a physician's referral or authorization if required, before your first visit. If insurance denies payment because the referral or authorization was not in place, you will be responsible for the payment of the fee to this office.

Workplace Injury Claims: In order for a Workers' Compensation claim to be filed by this office, we must verify the case with the employer and the insurance company. You must furnish us the information to do so.

Personal Injury Insurance: In order for our office to file claims to an automobile or homeowner's insurance company, you must furnish us with all the necessary information.

Medicare: This office does not participate with Medicare. We ask you to pay a discounted fee directly to our office and we will file the necessary paperwork to Medicare. You will receive only partial reimbursement of fees from Medicare.

I CERTIFY THAT I UNDERSTAND AND AGREE TO THE ABOVE POLICIES

SIGNATURE

Date

Anita Knopp DC

CONFIDENTIAL CHIROPRACTIC CASE HISTORY DATE __/__/__

LAST NAME _____ DATE OF BIRTH __/__/__

FIRST NAME _____ MIDDLE INITIAL _____

SOCIAL SECURITY NUMBER _____ - _____ - _____ Female ___ Male ___

STREET AND MAILING ADDRESS _____

CITY, TOWN _____ ZIP CODE _____

HOME TELEPHONE NUMBER () _____ - _____ E MAIL _____ @ _____

MAY THIS OFFICE E-MAIL YOU? ___ YES ___ NO

NAME OF EMPLOYER _____

WORK TELEPHONE NUMBER () _____ - _____

MAY THIS OFFICE CALL YOU AT WORK? ___ YES ___ NO

WHO REFERRED YOU TO THIS OFFICE? _____

NAME AND LOCATION OF YOUR GENERAL PHYSICIAN _____

MAY DR. KNOPP SEND A REPORT TO YOUR PHYSICIAN? ___ YES ___ NO

PLEASE CHECK THOSE THAT APPLY TO YOU:

___ I AM SEEKING HEALTH CARE DUE TO A WORKPLACE INJURY
(I HAVE FILED A WC CLAIM)

___ I AM SEEKING HEALTH CARE DUE TO A PERSONAL AUTOMOBILE
INJURY (DATE OF ACCIDENT __/__/__)

___ I PLAN TO USE MY HEALTH INSURANCE TO PAY MY FEES
(NOTE: NOT ALL PLANS ARE ACCEPTED BY THIS OFFICE)

___ I WILL BE PAYING FEES DIRECTLY TO THIS OFFICE.
(PLEASE SEE THE OFFICE MANAGER FOR INFO REGARDING FEES)

PLEASE FILL OUT THE FOLLOWING PAGES AS THOROUGHLY AS POSSIBLE.

THANK YOU FOR THIS VALUABLE INFORMATION.

Wellness & Chiropractic Care, LLC, PA, d/b/a Hagerty Chiropractic
298 Maine Street, Brunswick, ME 04011 (207) 729-8656

Anita Knopp DC

Name _____

Date _____

MEDICAL HISTORY

Date of patient's last medical examination? _____ With Dr. _____

Has Patient been hospitalized in the past five years? Y N When? _____

Reason _____

LIST CURRENT MEDICATIONS

CONDITIONS

Arthritis	Polio	AIDS
HIV ARC	Heart Disease	Allergies _____
Tuberculosis	Diabetes	Asthma
Epilepsy	Recent Weight Gain / Loss	Bowel, Bladder, Sexual Dys.
Thyroid Disorder	Rheumatic Fever	Skin Problems
Low / High Blood Pressure	Encephalitis	Digestive Disorder
Ulcer	Cancer	Visual / Hearing Problems
Kidney Stone	Night Sweats	
Dizziness	Heat / Cold Intolerance	Other: _____

FEMALE GENDER:

Hysterectomy: Total / Partial	Mastectomy: Total / Partial
Abnormal Bleeding	Painful Menses
Tubal Ligation	Other _____

Is there a possibility of pregnancy? Y N

How many pregnancies has patient had? _____ # Of Natural Births: ____ # Of Caesarian Section ____

MALE GENDER:

Prostate Disorder Other _____

Name _____

Date _____

INJURY HISTORY

__ Falling Injuries _____	When _____
__ Striking Blow to Head _____	When _____
__ Neck injury _____	When _____
__ Back injury _____	When _____
__ Loss of Consciousness _____	When _____
__ Concussion _____	When _____
__ Car/Motorcycle Accidents _____	When _____
__ Broken Bones _____	When _____
__ Other Physical Trauma/Abuse _____	When _____
__ Military Service _____	When _____

PREVIOUS AND CURRENT TREATMENT

What type of treatment has the patient received for his/her physical problem?

__ Medical _____	When? _____
__ Physical Therapy _____	When? _____
__ Osteopathic _____	When? _____
__ Other _____	When? _____

RESULTS: Better No Change Seems Worse

SELF - TREATMENT

Exercise Over Counter Medications Heating Pad Cold Packs Rest
 Other _____

RESULTS: Better No Change Seems Worse

IMAGING:

__ Spinal X-rays	When? _____	Where? _____
__ CAT SCAN	When? _____	Where? _____
__ MRI	When? _____	Where? _____
__ Other	When? _____	Where? _____

Is patient currently receiving medical or care for another health problem? Y N
 If YES, describe

Anita Knopp DC

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH ____/____/____

Release of Patient Records:

I give my permission to Anita Knopp, D.C. d/b/a Hagerty Chiropractic to release my records to the parties listed below:

Please list **Name** and **Location**

___ Primary Physician _____

___ Other Physician _____

___ Insurance Company _____

___ Attorney _____

___ Other _____

___ Release records directly to me.

SIGNATURE _____ DATE _____

Office Use Only	Released To:	Date	Pt. Initial	Returned
Materials Released:				

NOTE: PLEASE RETURN ALL ORIGINAL X-RAYS TO:

Wellness & Chiropractic Care, LLC, PA, d/b/a Hagerty Chiropractic
298 Maine Street, Brunswick, ME 04011 (207) 729-8656

AUTOMOBILE ACCIDENT QUESTIONNAIRE

PATIENT'S NAME: _____ **DOB** _____

CHECK SYMPTOMS PATIENT HAS NOTICED SINCE THE ACCIDENT:

- HEADACHE NECK PAIN NECK STIFF
- SLEEPING PROBLEMS BACK PAIN
- NERVOUSNESS TENSION IRRITABILITY
- CHEST PAIN HEAD SEEMS TOO HEAVY
- PINS & NEEDLES/ARMS PINS & NEEDLES/LEGS
- NUMBNESS/FINGERS NUMBNESS/TOES
- SHORTNESS OF BREATH FATIGUE
- DEPRESSION LIGHTS BOTHER EYES
- LOSS OF MEMORY EARS RING FACE FLUSHED
- BUZZING IN EARS LOSS OF BALANCE
- FAINTING LOSS OF SMELL
- LOSS OF TASTE DIARRHEA FEET COLD
- HANDS COLD STOMACH UPSET
- CONSTIPATION COLD SWEATS
- FEVER OTHER _____

AUTOMOBILE INJURY HISTORY

DATE _____

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE/ZIP _____

HOME PHONE _____ WORK PHONE _____ SS# _____

EMPLOYER'S NAME & LOCATION _____

DATE OF ACCIDENT _____ TIME OF DAY _____

WERE YOU: () DRIVER () PASSENGER () FRONT SEAT () BACK SEAT
() PEDESTRIAN

WAS THE IMPACT FROM: () THE FRONT () THE RIGHT SIDE () THE LEFT SIDE
() THE REAR

AT THE TIME OF IMPACT WERE YOU: () LOOKING STRAIGHT AHEAD
() LOOKING RIGHT () LOOKING LEFT

WERE YOU BRACED FOR IMPACT? () YES () NO

WAS YOUR FOOT ON THE BREAK AT THE TIME OF IMPACT? () YES () NO

WERE YOU AWARE OF THE IMPENDING ACCIDENT? () YES () NO

ESTIMATED SPEED AT IMPACT WAS _____ MILES PER HOUR.

AT THE TIME OF THE IMPACT, WAS THE ROAD () WET () DRY

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:

IS YOUR VEHICLE () COMPACT () MID SIZE () FULL SIZE () TRUCK
() SUV

WERE YOU WEARING A SEAT BELT? () YES () NO

IF YES, WAS IT A () LAP BELT () CHEST BELT () BOTH

DOES YOUR VEHICLE HAVE HEAD RESTRAINTS? () YES () NO

DID YOU STRIKE ANYTHING IN THE VEHICLE? () YES () NO

IF YES, WHAT DID YOU STRIKE? _____

IF YES, WHAT PORTION OF YOUR BODY DID YOU STRIKE? _____

AUTOMOBILE INJURY HISTORY CONTINUED

DID YOU GO HOME GO TO THE HOSPITAL RESUME NORMAL ACTIVITIES
IF TAKEN TO THE HOSPITAL, HOW DID YOU GET THERE? AMBULANCE
 FRIEND/RELATIVE DROVE YOURSELF WENT HOME BUT WENT TO THE HOSPITAL LATER
NAME OF HOSPITAL: _____

WERE YOU SEEN IN THE EMERGENCY ROOM? YES NO

WERE YOU ADMITTED TO THE HOSPITAL? YES NO

IF ADMITTED, HOW LONG DID YOU STAY? _____

NAME OF ADMITTING OR HOSPITAL DOCTOR _____

IN THE EMERGENCY ROOM, WHAT WAS DONE?

AFTER YOUR RELEASE WHAT DID YOU DO? RETURNED HOME RETURNED TO WORK
OTHER

WHEN DID YOU FIRST CONSULT A PHYSICIAN? SAME DAY FOLLOWING DAY WITHIN A
FEW DAYS OTHER

WHO DID YOU CONSULT? FAMILY PHYSICIAN ORTHOPEDIC NEUROLOGIST
CHIROPRACTOR OSTEOPATH OTHER

DO YOU HAVE A COPY OF THE POLICE REPORT? YES NO
IF YES, PLEASE BRING A COPY TO OUR OFFICE.

DID YOU HAVE ANY PHYSICAL COMPLAINTS **BEFORE** THE ACCIDENT? NO

YES IF YES, PLEASE DESCRIBE IN DETAIL:

PLEASE DESCRIBE HOW YOU FELT:

DURING THE ACCIDENT _____

IMMEDIATELY AFTER THE ACCIDENT _____

LATER THAT DAY _____

THE NEXT DAY _____

WHAT ARE YOUR **PRESENT** COMPLAINTS AND SYMPTOMS?