

KRUSE CHIROPRACTIC

5410 Page Road, Ste. 3

Durham, NC 27703

P: 919-474-8400 FX: 919-474-8486

Office policies for Personal Injury patients

This office will accept you as a new patient based on our clinical examination and belief that chiropractic care will be effective for the treatment of your injuries. Your responsibility to this office will be to follow the doctor's recommendations and to provide the appropriate financial information so that payment for services can be received.

Patients need to bring the following:

1- Copy of police report and/or a copy of the exchange slip.

2- Copy of personal automobile policy

This is to verify Medical Payments covered by your Automobile insurance.

3- Name of individual and insurance company of party that's liable. Please include policy number.

4- Name and telephone number of attorney if an attorney has been retained.

You are asked to give 24 hour notice if you need to reschedule an appointment. All appointments that have been missed without notice may be billed to your account.

Following the completion of your treatment in this office, your bill will be forwarded to the responsible party. Please note that this account is still your responsibility & will be subject to monthly interest charges of 1.5% effective 30 days following your initial visit.

Signature _____ date _____

KRUSE CHIROPRACTIC

5410 Page Road, Ste. 3 - Durham, NC 27703 - 919-773-4967 – FAX: 919-773-4968

ACTIVITIES OF DAILY LIVING

Name: _____ Condition: _____ Date: _____

1) Does anyone else in the family have this similar problem?

2) Before you began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly related to this problem? (Example: fall, auto injury, sports trauma, repetitive motion on job).

3) Since the time you began suffering from this problem, what if anything have you tried so far that has temporarily helped you? (Ex: Ice, Heat, Rest, OTC Meds, Prescriptions, Physical Therapy)
How Much _____ How Often _____?

4) Have you become discouraged/frustrated about this problem?

5) When this problem is at its worst, can you explain in your own words how exactly it feels?

6) How does that make you feel?

7) When this problem is at its worst does it make you feel older than you are? In other words, does this condition, the way you have described it so far seem to be normal for your age? YES or NO? How old?

8) Would you like for Dr. Kruse to send his findings over to your Primary Care Physician?

9) How does this problem affect your:

Family: _____

Work: _____

Hobbies: _____

Other: _____

10) Has this problem interrupted your sleep pattern yet? Either:

a) Trouble falling asleep due to being uncomfortable	YES	NO
b) Not enough restful sleep	YES	NO
c) Awaken in the middle of the night	YES	NO
d) Waking earlier than normally would	YES	NO

11) What activities does this problem prevent you from doing, either partially or totally, that you would really like to be doing again? _____

Doctor Signature: _____ Date: _____

AUTOMOBILE ACCIDENT QUESTIONNAIRE

Please Answer All Questions Completely

Date _____

Patient _____ No. _____

Sex _____ Marital Status _____ Date of Birth _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____

Who referred you to our office _____

Social Sec # _____ Business Phone _____ Company Name _____

Please explain in detail how your accident happened? _____

Driver of other vehicle (if any) _____ Date of Birth _____

Insurance Company _____ Address _____ Phone No. _____

Policy No. _____ Claim No. _____

Name of person who has made contact with you _____

Name of driver of vehicle in which you were injured (self or other) _____

Insurance Company _____ Address _____ Phone No. _____

Policy No. _____ Claim No. _____

Name of Person who has made contact with you _____

Have you retained an attorney? Yes No Not Yet

If so, his/her name, address & phone # _____

Give time and date present injury occurred _____ AM PM (date) ____/____/____

You were heading? North South East West on _____ (street or highway)

Number of people in your vehicle _____

Were police notified? Yes No Did head strike windshield or object? Yes No

Were you knocked unconscious? Yes No If so, for how long? _____

You were struck from? Behind Front Left Side Right Side

You were? Driver Passenger Front Seat Back Seat Using seat belts Other protective devices

Did you feel pain immediately after the accident? Yes No Later that day Next day When _____

Where did you feel pain immediately after the accident? _____

Where were you taken after the accident? _____

Was treatment given? _____

Was any doctor consulted after the accident? Yes No

If so, give doctor's name _____ D.C. M.D. D.O. D.D.S. _____

Doctor's Diagnosis _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? Yes No

If so, what were the complaints? _____

Before the injury, were you capable of working on an equal basis with others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since the injury, are your symptoms Improving? Getting worse? The same?