Chicoine Peterson
CHIROPRACTIC & NUTRITION
824 Morningside Avenue ❧ Sioux City, Iowa 51106 ❧ Phone: 712-276-9700 ❧ Fax: 712-276-9409

Dear Patient:

Thank you for choosing Chicoine Peterson Chiropractic & Nutrition for care. Most patients who are involved in accidents have insurance that will cover most of the services rendered in our office. In order for us to wait for the insurance to pay your bill, we require the following:

- THE NAME AND ADDRESS OF YOUR INSURANCE COMPANY.
- THE NAME OF THE CLAIMS ADJUSTER HANDLING YOUR CLAIM.
- AN OPEN AND WORKING CLAIM NUMBER ON YOUR CASE.

If you do not have the information today, please inform the front desk and make a phone call to your insurance company prior to seeing Dr. Chicoine. If you do not obtain this information prior to seeing Dr. Chicoine, you need to understand that we consider the charges to be your responsibility. As soon as we receive the requested information, we will be happy to wait for payment from your insurance AS LONG AS YOU ARE AN ACTIVE PATIENT. Should you discontinue care, the bill will become due and payable by you.

If you have an attorney involved in your case, please inform us immediately. We will ask your attorney to sign a lien.

Please do not hesitate to ask if you have any questions.

CHICOINE PETERSON CHIROPRACTIC & NUTRITION
DR. LIN L. CHICOINE PETERSON

_____ _____

Patient Signature Date

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The power that made the body heals the body
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ACCIDENTAL INJURY FORM

Name_____ Date_____

Date of Accident_____ Time: ____ am ____ pm Location of Accident_____

AUTO INJURY:

Were you: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

ON-THE-JOB INJURY

How did the injury occur? _____

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer: _____ Address:_____

OTHER

Describe the circumstances of the accident. (Be Specific) _____

_____

****

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache	( ) Irritability	( ) Numbness in Toes	( ) Face Flushed	( ) Feet Cold
( ) Neck Pain	( ) Chest Pain	( ) Shortness of Breath	( ) Buzzing in Ears	( ) Hands Cold
( ) Neck Stiff	( ) Sleeping Problems	( ) Fatigue	( ) Loss of Balance	( ) Stomach Upset
( ) Dizziness	( ) Head Too Heavy	( ) Depression	( ) Fainting	( ) Constipation
( ) Back Pain	( ) Pins & Needles in Arms	( ) Lights Bothers Eyes	( ) Loss of Smell	( ) Cold Sweats
( ) Nervousness	( ) Pins & Needles in Legs	( ) Loss of Memory	( ) Loss of Taste	( ) Fever
( ) Tension	( ) Numbness in Fingers	( ) Ears Ring	( ) Diarrhea	( ) Other

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, _____ through _____

INSURANCE INFORMATION

Your Insurance Company _____ Address _____

Other Party's Name _____ Address _____

Other Party's Ins. Co. _____ Address _____

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjuster _____ Company _____

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name _____ Address _____

Signature _____

PERSONAL INJURY/WORKERS' COMPENSATION QUESTIONNAIRE

NAME: _____ Date of Accident: _____ Time: _____

Where did accident happen? _____

Describe the accident in your own words: _____

_____

_____

What was your position in car? ☐ Driver ☐ Passenger If passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike other vehicle? ☐ Yes ☐ No Was your car struck by other vehicle? ☐ Yes ☐ No

Was the impact from: ☐ the front? ☐ from the right side? ☐ from the left side? ☐ from the rear?

At the time of impact were you: ☐ looking straight ahead? ☐ looking right? ☐ looking left?

Were both hands on steering wheel? ☐ Yes ☐ No Was your foot on brake? ☐ Yes ☐ No Were you braced for impact? ☐ Yes ☐ No

Where in the car were you after the accident? _____

Were you wearing seat belts? ☐ Yes ☐ No Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No

If yes, specify: ☐ Steering Wheel ☐ Dashboard ☐ Windshield ☐ Side Door ☐ Arm Rests ☐ Side Window

Please state part of body: ☐ Chest ☐ Chin ☐ Knee ☐ Shoulder ☐ Hand ☐ Head

Immediately following the accident how did you feel? _____

_____

Were you unconscious? ☐ Yes ☐ No In a daze? ☐ Yes ☐ No Did you go to hospital? ☐ Yes ☐ No

If you went to hospital, when? At time of accident ☐ Yes ☐ No Next day ☐ Yes ☐ No

How did you get to hospital? Ambulance ☐ Yes ☐ No Private Transportation ☐ Yes ☐ No

Did the ambulance attendants place you in: Neck Collar ☐ Yes ☐ No Splints: ☐ Yes ☐ No Brace: ☐ Yes ☐ No

Name of Hospital _____

Attended by Dr. _____ Were you x-rayed at hospital? ☐ Yes ☐ No

If so, what was the diagnosis? _____

Were you admitted to the hospital? ☐ Yes ☐ No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor? ☐ Yes ☐ No See orthopedic doctor? ☐ Yes ☐ No

Physical Therapy ☐ Yes ☐ No

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No

Doctor's name _____

Is your pain constant? ☐ Yes ☐ No Is the pain on and off? ☐ Yes ☐ No Sharp? ☐ Yes ☐ No Dull? ☐ Yes ☐ No

Other _____

Is your pain worse when arising from a chair? ☐ Yes ☐ No Is it made worse by straining? ☐ Yes ☐ No By coughing? ☐ Yes ☐ No

By sneezing? ☐ Yes ☐ No By straining when moving your bowels? ☐ Yes ☐ No

Do you have any numbness or tingling in your arms? ☐ Yes ☐ No In your hands? ☐ Yes ☐ No In your fingers? ☐ Yes ☐ No

In your legs? ☐ Yes ☐ No In your feet? ☐ Yes ☐ No In your toes? ☐ Yes ☐ No

What is your most comfortable position? Sitting ☐ Yes ☐ No Lying on your right side ☐ Yes ☐ No Lying on your left side ☐ Yes ☐ No

Lying on your back ☐ Yes ☐ No On your stomach ☐ Yes ☐ No Standing ☐ Yes ☐ No

Other _____ Is it difficult for you to move around in bed? ☐ Yes ☐ No

Does stretching and twisting worsen the pain? ☐ Yes ☐ No

Do any of the following relieve your pain? ☐ Heating Pad ☐ Hot Bath ☐ Shower ☐ Ice Pack

Does a brace (if you have tried one) help relieve the pain? ☐ Yes ☐ No

Does a change in heel height worsen the pain? ☐ Yes ☐ No Do you feel better moving around? ☐ Yes ☐ No Or resting? ☐ Yes ☐ No

Do you have a firm mattress? ☐ Yes ☐ No Do your knees ache or hurt? ☐ Yes ☐ No Do you have cramps in your leg? ☐ Yes ☐ No

In arm? ☐ Yes ☐ No Have you had any change in your bowel habits? ☐ Yes ☐ No

Have you lost any time from work because of this accident? ☐ Yes ☐ No

If yes, give dates of time lost. From _____ To _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

BEFORE YOUR ACCIDENT, estimate your total lifting effort ability:

1. How much weight? ☐ Maximum ☐ Average
2. How far could you carry this weight? _____ For how long a period of time? _____
3. Was this lifting done at work? ☐ Yes ☐ No Or at home or elsewhere? ☐ Yes ☐ No
4. How often did you carry this amount of weight? _____

AFTER YOUR ACCIDENT, describe your total lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort, or restriction of motion? _____
2. Did you experience this pain, discomfort or restriction of motion before your accident? ☐ Yes ☐ No
3. How far can you carry this weight now? _____ And for how long a period of time? _____
4. How often can you carry this weight? _____
5. Are you now limited in your lifting ability in some body position that you were previously not? ☐ Yes ☐ No

   If so, specify position _____
6. What symptoms does lifting produce? _____
7. How long do these symptoms last? _____

Are you presently able to:

LIFT	☐ Very Heavy _____ lbs.	☐ Heavy _____ lbs.	☐ Light _____ lbs.	☐ Sitting _____ lbs.
WORK	☐ Very Heavy _____ lbs.	☐ Heavy _____ lbs.	☐ Light _____ lbs.	☐ Sitting _____ lbs.

What positions can you work in with a MINIMUM DEMAND of physical effort?

With Minimum Demand of physical effort, what positions can you work in PART-TIME and for how long?

☐ Standing ☐ Walking ☐ Sitting

With Minimum Demand of physical effort, can you work in a SITTING POSITION with some degree of walking or standing activity?

☐ Yes ☐ No

Do you feel that you cannot perform any physical work activity? ☐ Yes ☐ No

Do you feel that you cannot perform any mental work? ☐ Yes ☐ No

Relate your BEFORE injury capacity (mark 'B') and your AFTER injury capacity (mark 'A') for performing activities:

1. Walking	Normal _____	Limited _____	Difficult _____	Pain _____
2. Standing	Normal _____	Limited _____	Difficult _____	Pain _____
3. Sitting	Normal _____	Limited _____	Difficult _____	Pain _____
4. Bending	Normal _____	Limited _____	Difficult _____	Pain _____
5. Stooping	Normal _____	Limited _____	Difficult _____	Pain _____
6. Lifting	Normal _____	Limited _____	Difficult _____	Pain _____
7. Pushing	Normal _____	Limited _____	Difficult _____	Pain _____
8. Pulling	Normal _____	Limited _____	Difficult _____	Pain _____
9. Climbing	Normal _____	Limited _____	Difficult _____	Pain _____
10. Reaching	Normal _____	Limited _____	Difficult _____	Pain _____
11. Gripping	Normal _____	Limited _____	Difficult _____	Pain _____
12. Kneeling	Normal _____	Limited _____	Difficult _____	Pain _____
13. Balance	Normal _____	Limited _____	Difficult _____	Pain _____
14. Fatigue	Normal _____	Limited _____	Difficult _____	Pain _____

Generally speaking, is your inability to perform these functions due to ☐ Pain ☐ Weakness ☐ Structural limitations ☐ Nerves?

Do you have normal sexual function? ☐ Yes ☐ No

Are you able to take care of your personal self, such as dressing, bathing, etc.? ☐ Yes ☐ No Or do you require assistance? ☐ Yes ☐ No

Do you feel your present condition is temporary? ☐ Yes ☐ No Or permanent? ☐ Yes ☐ No

Patient's Signature _____ Date: _____

WORKERS' COMPENSATION
AUTHORIZATION FOR TREATMENT

Patient _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Date of Accident: _____
Address: _____ City: _____ State: _____ Zip: _____

TO THE PATIENT: It is necessary that you employer sign the following Authorization for Treatment and return to our office. If not, you will be responsible for payment.

TO THE EMPLOYER: I acknowledge the work related injury of the above named patient. You are authorized to render the appropriate care needed for this injury and we will file the proper forms with our insurance carrier.

Authorized by: _____
Title: _____
Date: _____

PLEASE RETURN THIS FORM IMMEDIATELY TO: Doctor's / Clinic Name _____
Address: _____
City, State, Zip: _____
Telephone: ( ) _____