

VAN HEMERT CHIROPRACTIC CLINIC

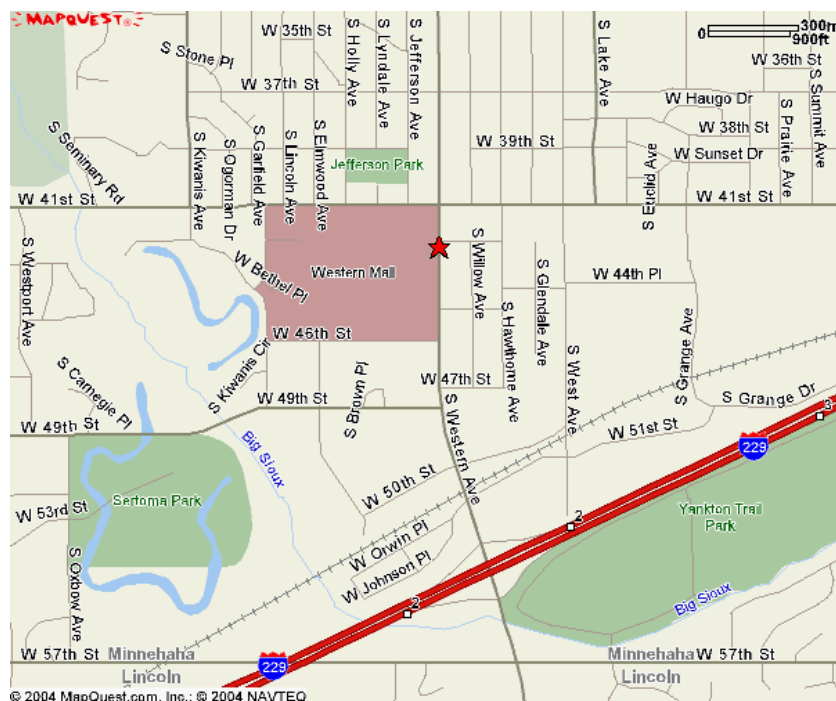
Paperwork for Auto Accident

INSTRUCTIONS:

To make your appointment to go as quickly and smoothly as possible please:

1. Fill out the application for treatment sheets, two of them, and sign both of them accordingly.
2. If the appointment is for a minor, please read the **Consent to Treat a Minor** carefully and sign accordingly.
3. Fill out the patient history sheet with any and all past history.
4. If you have neck or low back pain fill out the appropriate questionnaire, one or both.
5. Fill out the auto accident information sheet.
6. Alert our staff that you have downloaded and filled out your paperwork when you call or you can schedule an appointment online. This will give you a priority appointment in our office.

Thank you for choosing Van Hemert Chiropractic Clinic for your health care
Our phone number is (605) 331-4220 and our address is 3508 S. Western Ave,
Sioux Falls, SD 57105.



APPLICATION FOR TREATMENT

Legal Name: _____ Date _____
Last First Middle Initial

Date of Birth _____ E-Mail _____

Address: _____ City _____ State _____ Zip _____

Home Phone# _____ Cell# _____ Work# _____ Martial Status: M S D W SEP

Social Security#: _____ Ages of Children: _____

How did you hear about our clinic: 1) _____ 2) _____

Please check any payment types that may apply: Cash ___ Major Medical ___ Workers' Comp ___
Auto Accident ___ Medicare ___ Medicaid ___

If Patient is a Minor, Go to Consent to Treat a Minor/Responsible Party Information Listed in the Box Below:

Patient's Employer: _____ Spouse's Employer: _____

Spouse's Name: _____ Birth Date _____ Social Security#: _____

CONSENT TO TREAT A MINOR/ RESPONSIBLE PARTY

Father's Name: _____ Birth Date: _____ Social Security#: _____

Address: _____ City _____ State _____ Zip _____

Father's Employer: _____ Work Phone#: _____

Mother's Name: _____ Birth Date: _____ Social Security#: _____

Address: _____ City _____ State _____ Zip _____

Mother's Employer: _____ Work Phone#: _____

Consent to Evaluate and Treat: I certify that I have rights to and do give the staff at Van Hemert Chiropractic Clinic, it's doctors, and paraprofessional staff members to evaluate and treat with tests, examinations, or treatment that they feel is necessary for this minor.

Signed: _____ Legal Relationship(parent/guardian,ect.) _____ Date: _____

The patient understands and agrees to allow Van Hemert Chiropractic Clinic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent. If there is anyone, you do not want to receive your medical records, please inform our office.

Patient's or Guardian's Signature _____ Date _____

PATIENT HISTORY

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Past	Present	Past	Present			
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Mid back pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>	Upper limb weakness	<input type="checkbox"/>	<input type="checkbox"/>	Aortic aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Upper limb pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorders	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Elbow pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction
<input type="checkbox"/>	<input type="checkbox"/>	Wrist pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction
<input type="checkbox"/>	<input type="checkbox"/>	Hand pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hip pain	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis
<input type="checkbox"/>	<input type="checkbox"/>	Leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Tension
<input type="checkbox"/>	<input type="checkbox"/>	Knee pain	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/foot pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Irritable colon
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Liver disorder
<input type="checkbox"/>	<input type="checkbox"/>	General fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Visual disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus(ear noises)	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to sound	<input type="checkbox"/>	<input type="checkbox"/>	Memory problems
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases						

Females only

<input type="checkbox"/> <input type="checkbox"/> Irregular periods	<input type="checkbox"/> <input type="checkbox"/> Severe cramps	<input type="checkbox"/> <input type="checkbox"/> Excessive flow
<input type="checkbox"/> <input type="checkbox"/> PMS	<input type="checkbox"/> <input type="checkbox"/> Endometriosis	<input type="checkbox"/> <input type="checkbox"/> Pregnancy
<input type="checkbox"/> <input type="checkbox"/> Birth control pills	<input type="checkbox"/> <input type="checkbox"/> Hormonal replacement	

Males only

<input type="checkbox"/> <input type="checkbox"/> Prostate problems	<input type="checkbox"/> <input type="checkbox"/> Erectile dysfunction
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List any surgeries you have had: _____

Do you have a permanent disability rating: No Yes Rating% _____ Date rating received: _____

List all medication you are taking: _____

Family Physician: _____ Location: _____

Print name: _____ Signature: _____ Date: _____

Neck Pain and Disability Index (Vernon-Mior)

Patient name: _____ Date: _____

Please read these instructions: This questionnaire has been designed to give your doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer the sections below that apply to you with only the ONE BEST check mark that applies to you. If a particular section does not apply just leave it blank. We realize that you may consider two statements but please just mark the ONE BEST statement that most closely describes your problem.

SECTION 1: PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2: PERSONAL CARE(Washing, Dressing,ect.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3: LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4: READING

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

SECTION 5: HEADACHES

- I have no headaches at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

SECTION 6: CONCENTRATION

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

SECTION 7: WORK

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I cannot do any work at all.

SECTION 8: DRIVING

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I cannot drive my car at all.

SECTION 9: SLEEPING

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10: RECREATION

- I am able to engage in all my recreation activities with no neck pain at all.
- I am able to engage in all my recreation activities, with some pain in my neck.
- I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- I am able to engage in a few of my usual recreation activities because of pain in my neck.
- I can hardly do any recreation activities because of pain in my neck.
- I cannot do any recreation activities at all.

With Permission from: Veron H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991; 14:409-415, Copyright Veron H and Hagino C, 1990.

Pain Scale: Rate the severity of your pain by checking the ONE box that best describes your pain on the scale below, with 0 representing no pain and 10 representing severe pain.

0	1	2	3	4	5	6	7	8	9	10
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Low Back Pain and Disability Index (Revised Oswestry)

Patient name: _____ Date: _____

Please read these instructions: This questionnaire has been designed to give your doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer the sections below that apply to you with only the ONE BEST check mark that applies to you. If a particular section does not apply just leave it blank. We realize that you may consider two statements but please just mark the ONE BEST statement that most closely describes your problem.

SECTION 1: PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

SECTION 2: PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increase the pain but I manage not to change my way of doing it.
- Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

SECTION 3: LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very light weights at the most.

SECTION 4: WALKING

- I have no pain on walking.
- I have some pain on walking but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than 1/2 mile without increasing pain.
- I cannot walk more than 1/4 mile without increasing pain.
- I cannot walk at all without increasing pain.

SECTION 5: SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than half hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain straight away.

SECTION 6: STANDING

- I can stand as long as I want without pain.
- I have some pain on standing but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than 1/2 hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

SECTION 7: SLEEPING

- I get no pain in bed.
- I get pain in bed but it does not prevent me from sleeping well.
- Because of pain my normal night's sleep is reduced by less than 1/4.
- Because of pain my normal night's sleep is reduced by less than 1/2.
- Because of pain my normal night's sleep is reduced by less than 3/4.
- Pain prevents me from sleeping at all.

SECTION 8: SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

SECTION 9: TRAVELLING

- I get no pain while travelling.
- I get some pain while travelling but none of my usual forms of travel make it any worse.
- I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- I get extra pain while travelling which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

SECTION 10: CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates but overall is definitely getting better.
- My pain seems to be getting better but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

With Permission from: Hudson-Cook N, Tomes-Nicholson K, Breen AC. A Revised Oswestry Back Disability Questionnaire. Manchester Univ Press, 1989.

Pain Scale: Rate the severity of your pain by checking the ONE box that best describes your pain on the scale below, with 0 representing no pain and 10 representing severe pain.

0	1	2	3	4	5	6	7	8	9	10
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AUTO ACCIDENT INFORMATION

Date of Accident: _____ Describe the accident in your own words: _____

Where did you go after the accident: Home ___ Work ___ Hospital ___

If you went to the hospital how did you get there: Private transportation ___ Ambulance ___

In the vehicle where were you seated: _____

Where in the vehicle were you after the accident: _____

Were there any other people in the vehicle: Yes ___ No ___ If so, did any of them come in contact with you during the crash: Yes ___ No ___ If yes, describe: _____

Did you strike any object in the vehicle: Yes ___ No ___ If yes, describe: _____

Make, model, and year of the vehicle you were in: _____

Estimated speed of your vehicle at the time of the crash: _____ mph. Estimate damage to your vehicle: \$ _____ Was your vehicle stopped ___ decelerating ___ accelerating ___

Make, model, and year of the other vehicle: _____

Estimated speed of the other vehicle at the time of the crash: _____ mph. Estimate damage to the other vehicle: \$ _____ Was the other vehicle stopped ___ decelerating ___ accelerating ___

Time of day that the accident happened: _____

Road surface: Cement ___ Asphalt ___ Gravel ___ Other ___

Road condition: Dry ___ Damp ___ Wet ___ Snow ___ Ice ___ Other ___

Head restraints: Up ___ Down ___ Unsure ___ Was the seat broken Yes ___ No ___

Was the seat altered by the accident: Yes ___ No ___ If yes, describe: _____

Were you wearing a seat belt: Yes ___ No ___ If yes, what type of belt: Lap ___ Shoulder Harness ___

Aware of the impending collision: Yes ___ No ___ Did an airbag strike you: Yes ___ No ___

If you were the driver how were your hands placed on the steering wheel: _____

Where were you looking at the time of impact: Forward ___ Left ___ Right ___ Up ___ Down ___

Brakes applied: Yes ___ No ___ Did your vehicle strike any other vehicles or objects: Yes ___ No ___ If yes, explain: _____

Did you lose consciousness: Yes ___ No ___ Were the police called to the scene: Yes ___ No ___

If yes, was a report made: Yes ___ No ___

Additional Comments: _____

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

Headache ___ Neck Pain ___ Neck Stiff ___ Sleeping Problems ___ Mid Back Pain ___ Low Back

Pain ___ Irritability ___ Dizziness ___ Head Seems Too Heavy ___ Pins & Needles In Arms ___

Pins & Needles In Legs ___ Numbness In Fingers ___ Numbness in Legs ___ Fatigue ___

Depression ___ Light Bothers Eyes ___ Sound Bothers Ears ___ Ears Ring ___ Loss of

Memory ___ Faced Flushed ___ Loss of Balance ___ Loss of Smell or Taste ___ Concentration

Problems ___ No Control of Emotions ___ Does Not Enjoy Sex ___ Arithmetic Problems ___

Symptoms other than those above: _____

Print name: _____ Signature: _____ Date: _____