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. Please be sure to ask about our CareCredit Program that enables easy 0% interest monthly payments.

Thank you for choosing Align Chiropractic with Dr. Lyle Van Hemert 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 Align Chiropractic, its doctors, and paraprofessional staff members to evaluate and treat with tests, examinations, or treatment that they feel is necessary for this minor.

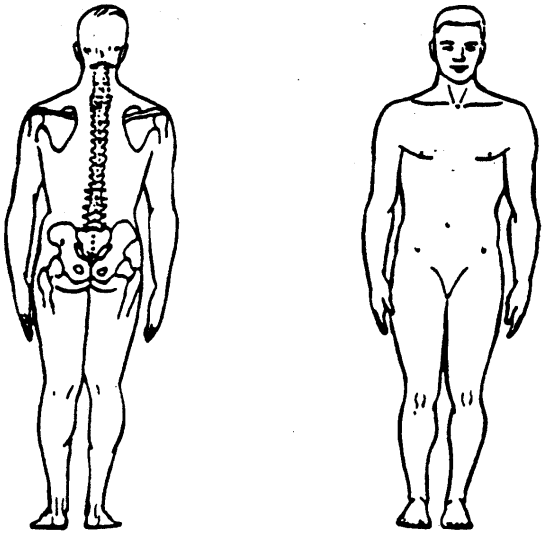
Signed:_____ Legal Relationship(parent/guardian,ect.)_____ Date:_____

The patient understands and agrees to allow Align Chiropractic 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_____

APPLICATION FOR TREATMENT PAGE TWO

COMPLETE THESE DIAGRAMS Please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, burning, constant, off & on, standing, sitting, ect.



MAJOR COMPLAINTS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How did this condition develop: (What caused it? How and when did it start?)____
_____
_____

Have you ever had this problem or similar problem before? If yes, please explain:_____
_____
_____

Has the problem been getting better, worse, or staying the same?_____

Is there anything that you can do to make it better or worse?_____
_____

Have you ever received any treatment for this condition? If yes, when, where, and what were your results?____
_____
_____

Have you ever been in an automobile accident? If yes, list the details:_____
_____
_____

ANY ACCIDENTS, FALLS, ECT., THAT MAY HAVE CAUSED YOUR PROBLEM? If yes, explain:_____
_____

Have you seen any other chiropractor in the past:_____If yes, Please list who it was, for what condition and when:_____
_____
_____

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

Females only

___	___	Irregular periods	___	___	Severe cramps	___	___	Excessive flow
___	___	PMS	___	___	Endometriosis	___	___	Pregnancy
___	___	Birth control pills	___	___	Hormonal replacement			

Males only

___	___	Prostate problems	___	___	Erectile dysfunction

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.

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

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 is 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.

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

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 loose consciousness: Yes__ No___ Were the police called to the scene: Yes___ No___ If yes, was a report made:Yes___ No___
AdditionalComments:_____
_____
_____

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:_____