Cascade Chiropractic

1501 Hwy 18 Byp Ste B, Hot Springs, SD 57747

About the Patient

Name:_____ Today's Date:_____ Birthdate:_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone: _____ Work Phone: _____ Gender: M F

Significant Other's Name: _____ Kid's Names and Ages: _____

Your Employer:_____ Type of Work:_____

E-Mail Address:_____ Have you been to a chiropractor before: Y N

Emergency Contact:_____ Phone #:_____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- I authorize the Cascade Chiropractic staff to request records from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that all care is rendered at usual and customary fees.
- I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected.
- To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient/Parent Signature:_____ Date:_____

Reason for Seeking Care

Presents Complaints

1._____ How long has this been an issue?_____

2._____ How long has this been an issue?_____

3 ._____ How long has this been an issue?_____

4._____ How long has this been an issue?_____

5. Does your condition affect: (circle any that apply) Sleep Work Daily Routine Sitting Driving

Other: _____

6. What makes it better? _____

7. What make it worse? _____

8. What Doctors have you seen for this? _____

9. Type of treatment: _____

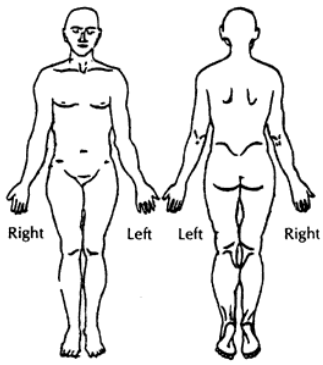
10. Results: _____

Notes: _____

_____

Are you Pregnant?

Yes No



Please mark all areas of concern

Cascade Chiropractic

1501 Hwy 18 Byp Ste B, Hot Springs, SD 57747

General Health History

Patient Name_____ Mark the conditions that apply to you.

Past	Present		Past	Present	
0	0	Headaches	0	0	Urinary Problems
0	0	Migraines	0	0	Easy Bruising
0	0	Shortness of Breath	0	0	Tobacco Use
0	0	Allergies / Asthma	0	0	Dental Problems
0	0	Medication Side Effects	0	0	Fibromyalgia
0	0	Diabetes	0	0	Blood Thinner use
0	0	Hands or Feet cold	0	0	HIV Positive
0	0	Muscle aches	0	0	Cancer
0	0	Trouble Walking	0	0	Depression
0	0	Leg / Foot Numbness	0	0	Alcohol Use
0	0	Fainting	0	0	___High or ___Low Blood Pressure
0	0	Gall Bladder Trouble	0	0	Stroke History
0	0	Ringing in Ears	0	0	High Cholesterol
0	0	Ear Problems	0	0	TMJ
0	0	Sleeping Problems	0	0	Digestive Problems
0	0	Vision Problems	0	0	Pain all Over
0	0	Thyroid Problems	0	0	Tension / Irritability
0	0	Liver Disease	0	0	Chest Pains
0	0	Kidney Problems	0	0	Heart Pacemaker
0	0	Light Bothers Eyes	0	0	Heart Problems
0	0	Other _____			

1. List any medications you are taking:_____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor": 0 No 0 Yes, if yes Name _____

Past History

4. List any past auto collisions:_____ Was any care received?_____

5. List any past work injuries: _____ Was any care received?_____

6. List any past sport, recreational, or home injuries_____

7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

Family History

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Oswestry Disability Index

Patient Name:_____ Date:_____

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, etc.)

- ❑ I can look after myself normally without it 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 my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, 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 (i.e. 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 only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Walking

- ❑ Pain does not prevent me walking any distance.
- ❑ Pain prevents me walking more than 1mile.
- ❑ Pain prevents me walking more than ¼ of a mile.
- ❑ Pain prevents me walking more than 100 yards.
- ❑ I can only walk using a stick or crutches.
- ❑ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ❑ I can sit in any chair as long as I like.
- ❑ I can sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ Pain prevents me from sitting at all.

Section 6 – Standing

- ❑ I can stand as long as I want without extra pain.
- ❑ I can stand as long as I want but it gives me extra pain.
- ❑ Pain prevents me from standing more than 1 hour.
- ❑ Pain prevents me from standing for more than ½ an hour.
- ❑ Pain prevents me from standing at all.

Section 7 – Sleeping

- ❑ My sleep is never disturbed by pain.
- ❑ My sleep is occasionally disturbed by pain.
- ❑ Because of pain, I have less than 6 hours sleep.
- ❑ Because of pain, I have less than 4 hours sleep.
- ❑ Because of pain, I have less than 2 hours sleep.
- ❑ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ❑ My sex life is normal and causes no extra pain.
- ❑ My sex life is normal but causes some extra pain.
- ❑ My sex life is nearly normal but is very painful.
- ❑ My sex life is severely restricted by pain.
- ❑ My sex life is nearly absent because of pain.
- ❑ Pain prevents any sex life at all.

Section 9 – Social Life

- ❑ My social life is normal and cause me no extra 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, i.e. sports.
- ❑ Pain has restricted my social life and I do not go out as often.
- ❑ Pain has restricted social life to my home.
- ❑ I have no social life because of pain.

Section 10 – Traveling

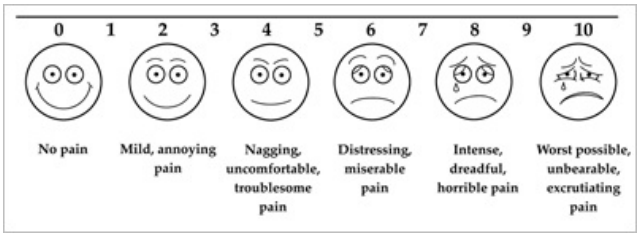
- ❑ I can travel anywhere without pain.
- ❑ I can travel anywhere but it gives extra pain.
- ❑ Pain is bad but I manage journeys of over two hours.
- ❑ Pain restricts me to short necessary journeys under 30 minutes.
- ❑ Pain prevents me from traveling except to receive treatment.

Section 11 - Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- ❑ No
- ❑ Yes (if yes, please state the type of treatment you have received)

Circle your Pain Level



Cascade Chiropractic

1501 Hwy 18 Byp Ste B
Hot Springs, SD 57747
605-745-5119

Paying for your care

Please initial next to the option that applies to you

No insurance? Great! Most insurance companies don't pay well for chiropractic anyways! The first visit will cost between $50-$149 we will then create an affordable plan to get you feeling great again! _____

Regular health insurance we are in-network and accept most insurances. Your plan limits your coverage and sets your fees. You can use your HSA, HRA and Flex dollars here! We will be happy to verify any benefits and let you know during your second visit to our office. Your first visit today will cost between $50-$149. _____

Medicare does not pay for exams and x-rays so the first visit will be $115. Medicare then covers 80% for up to 12 weeks. _____

Auto Accident injuries are covered 100%._____

Work Comp injuries are covered 100% for 12 weeks. _____

Workers Compensation Injury Form

Cascade Chiropractic

1501 Hwy 18 Byp Ste B, Hot Springs, SD 57747

Patient Name:_____ Date:_____

1. Date of injury:_____ Location (city, state):_____
2. Name of Employer/Manager:_____ Contact information:_____
3. Did you file a claim and/or notify your employer in writing within 3 days of the accident? Y N
4. Describe the accident in your own words:_____

_____

5. At the time of the accident where did you feel pain:_____

_____

6. Did you go to the hospital? Y N
    a. If yes where at: _____ When:_____
    b. Did you go by ambulance? Y N
    c. Were x-ray or other images taken? Y N
    d. Have you lost any days of work? Y N
7. Other than emergency room personnel has anyone treated you for this injury? Y N
    a. If yes, do you have written approval from employer or a written referral from person treating you for chiropractic care? Y N

Patient or parent Signature: _____ Date:_____

Witness:_____ Date:_____

According to the South Dakota Department of Labor and Regulation's website (11/2016) here are some of the benefits available to you after a work injury. Please sign below indicating you have read these and are willing to comply with any rules/regulations set out by the South Dakota Department of Labor and Regulation. The information below should in no way be considered legal advice. For specific information about your legal rights, you should consult your personal attorney. If you have a general question, contact South Dakota Department of Labor and Regulation, Division of Labor and Management, 123 W. Missouri Ave., Pierre, SD 57501, Phone: 605.773.3681

Doctors and Second Opinions

You have the right to choose your doctor, but you must notify your employer of your choice prior to treatment (or as soon as reasonably possible after treatment). Emergency room treatment does not count as your choice. If you want to change doctors, you must get written permission from your employer or the insurer.
If you want a second opinion, you must pay for that yourself. Your employer and the insurer also have the right to a second opinion with the doctor of their choice at their expense.

Returning to Work

If your doctor says you can return to work for part-time or modified work and your employer can accommodate the restrictions, state law requires you to accept the employment. Refusing to accept light-duty work means risking the loss of some or all of your workers' compensation benefits.
If you accept the modified or light-duty work and are earning less than what you were earning at the time of your injury, you may be entitled to temporary partial disability benefits. This benefit is calculated as half the difference between the average amount you earned before the injury and the average amount you earn or are able to earn after the injury.

Benefits Available

Your employer (via the insurance carrier) must furnish all necessary first aid, medical, surgical, rehabilitation and hospital services, including prosthetic devices, body aids and physical rehabilitation.
Sometimes the expenses of travel, lodging and meals associated with a trip to receive medical treatment for a work-related injury may be reimbursed.
If you lose wages because your doctor will not let you work while injured for at least seven consecutive calendar days, you are entitled to temporary total disability benefits. The benefit is computed at two-thirds of your average weekly wage (limiting overtime earnings to straight-time pay) up to a maximum of $705 per week. The benefits continue until your doctor releases you to return to work in a full or partial capacity, or until the doctor determines that your condition is not going to improve any further.

Patient or parent Signature: _____ Date:_____

Witness:_____ Date:_____