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Reset Form

Back Specialists
Sioux Falls, SD 57108
Auto/Work Related Accident

About You:

Name:_____ SS#:_____/_____/_____ Date of Birth:_____/_____/_____

Automobile Accident Related:

Date and Time of Accident:_____ ☐ a.m. ☐ p.m. Number of people in vehicle:_____
Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger
If a traffic violation was issued, to whom was it issued?_____
Did the police come to the accident site? ☐ yes ☐ no Was a police report filed? ☐ yes ☐ no
Were there any witnesses? ☐ yes ☐ no Were you wearing a seatbelt? ☐ yes ☐ no
Was this vehicle equipped with airbags? ☐ yes ☐ no If yes, did it inflate? ☐ yes ☐ no
In relation to the base of your skull, where was the headrest? ☐ above ☐ below ☐ at base of skull
What did your vehicle impact? ☐ another vehicle ☐ other-if other, explain: _____
_____
Did any part of your body strike anything in the vehicle? ☐ yes ☐ no if yes, explain:_____
_____
Make, model and year of vehicle you were occupying?_____
Name of the location/street on which you were traveling?_____
In which direction were you headed? ☐ N ☐ S ☐ E ☐ W Speed of the other vehicle?_____
In your words, please describe the accident:_____
_____
_____

Work Related Injury:

Date and Time of Accident:_____ ☐ a.m. ☐ p.m.
Was your accident directly related to your work? ☐ yes ☐ no
Briefly describe the events that occurred just before and during your accident:_____
_____
Give the address where your work accident occurred (if other than employer's address):_____
_____
Was anyone else present during your accident? ☐ yes ☐ no Did you report it to your employer? ☐ yes ☐ no
What recommendations did your employer make just after your accident?_____
Has this type of accident happened to you before? ☐ yes ☐ no
To the best of your knowledge has this type of accident occurred in your workplace before? ☐ yes ☐ no
In general: Is your job physically stressful? ☐ yes ☐ no Is your job mentally stressful? ☐ yes ☐ no
Is your workplace noisy? ☐ yes ☐ no Have you changed jobs in the last year? ☐ yes ☐ no

Insurance Information:

Is this case covered by insurance? ☐Group Health ☐Work Comp ☐Personal Injury ☐Disability ☐None
Insurance Company: _____ (please provide a copy of your card)
First Insured's Name:_____ (name insurance is listed under)
First Insured's Date of Birth:_____-_____-_____ First Insured's ID#:_____

Comments:

_____

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Back Specialists
Sioux Falls, SD 57108
Auto/Work Related Accident

After Injury:

Did accident render you unconscious? ☐ yes ☐ no If yes, for how long?_____
Please describe how you felt immediately after the accident:_____
_____
_____
Have you gone to a Hospital or seen any other Doctor for this incident? ☐ yes ☐ no
When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus afterward
How did you get there? ☐ Ambulance ☐ Private transportation Name of Hospital:_____
Attending Doctor was a he/she: ☐ Chiropractor ☐ Medical ☐ Physical Therapist ☐ Osteopath ☐ Other
Describe any treatment you received:_____
_____Were x-rays taken? ☐ yes ☐ no
Was medication prescribed? ☐ yes ☐ no Have you been able to work since the injury? ☐ yes ☐ no
Are your work activities currently restricted as a result of this injury? ☐ yes ☐ no

✓ **Indicate the symptoms that are a result of this accident: (reading from left to right)**

☐ Arms/Shoulder Pain	☐ Back Pain	☐ Back Stiffness	☐ Blurred Vision
☐ Buzzing in Ear	☐ Chest Pain	☐ Difficulty Sleeping	☐ Dizziness
☐ Ears Ringing	☐ Fatigue	☐ Headache (s)	☐ Irritability
☐ Jaw Problems	☐ Leg Pain	☐ Lower Back Pain	☐ Memory Loss
☐ Nausea	☐ Neck Pain	☐ Neck Stiff	☐ Numb Feet/Toes
☐ Numb Hands/Fingers	☐ Shortness of Breath	☐ Stomach Upset	☐ Tension
☐ Other_____			

Is your condition getting worse? ☐ yes ☐ no ☐ constant ☐ comes and goes

Indicate your degree of comfort while performing the following activities by marking accordingly:
C = comfortable U = uncomfortable P = painful

____Bending	____Kneeling	____Lifting	____Lying on Back
____Lying on Side	____Lying on Stomach	____Pulling	____Reaching
____Running	____Sitting	____Sports	____Standing
____Stretching	____Walking	____Working	____Other_____

Have you retained an attorney: ☐ yes ☐ no If yes, whom:_____Telephone:_____

Recovery:

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal work day? _____
Please indicate your daily job duties and activities which you are occasionally asked to perform by ✓ the line:

☐ Bending	☐ Crawling	☐ Driving	☐ Lifting
☐ Operating Equipment	☐ Sitting	☐ Standing	☐ Stooping
☐ Twisting	☐ Typing	☐ Walking	☐ Work with arms above head
☐ Other_____			

What positions can you work in with minimal physical effort and for how long?_____
Prior to the injury were you capable of working on an equal basis with others in your age? ☐ yes ☐ no ☐ n/a
Do you work with others who can help you with any heavy lifting? ☐ yes ☐ no ☐ n/a
While in recovery, is there any light duty work you could request? ☐ yes ☐ no ☐ n/a

Authorization to Treat:

- **If any of your medical or account information changes throughout the course of your care with us please be sure to notify our patient assistant immediately.**
- **Remember you are ultimately responsible for your account with *Back Specialists*, so providing us with accurate and timely information is expected.**
- **Your signature below authorizes us to treat you for the health concerns you have listed herein.**

Patient Signature:_____**Date**____/____/____

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Reset Form

Back Specialists
Sioux Falls, SD

PATIENT INFORMATION

Payment is expected at the time of visit unless prior arrangements have been made.

Patient Information:

First Name:_____MI:_____Last Name:_____
Street: _____Apt :_____
City: _____State:_____Zip:_____
Social Security #:_____-_____-_____ Marital Status: ___S___M___W___D Spouse:_____
Language:___English___Spanish___Indian___Japanese___Chinese___Korean___French___German
___Russian___Other_____
Race:___White___American Indian or Alaska Native___Asian___Native Hawaiian/Other Pacific Islander
___Black or African American___Decline to answer___Other
Ethnicity:___Hispanic or Latino___Not Hispanic or Latino___Decline to answer
DOB:_____Home Phone:_____-_____-_____Work Phone:_____-_____-_____
Cell Phone:_____-_____-_____ Cell Carrier:_____
Please check your contact preference:___Hm___Wk___Cell___Email___Post Mail
Email Home:_____ Email Work:_____
Emergency Contact:_____Phone Number:_____-_____-_____
Who may we thank for referring you to our office?_____
Occupation:_____Employer:_____
Employer Address:_____

We will make a copy of your insurance card/s. However, please complete the following information.

Insurance Information:

Are you the policy holder___Y___N If no, who is policy holder___Spouse___Parent___Employer___Other
Policy Holder First Name:_____MI___Last Name_____
Policy Holder's DOB:_____Policy Holder's SS#_____-___-_____
Policy Holder's Employer:_____
Do you have secondary insurance coverage___Y___N If yes, please complete the following:
Policy Holder First Name:_____MI___Last Name_____
Policy Holder's DOB:_____Policy Holder's SS#_____-___-_____
Policy Holder's Employer:_____

Patient History:

Are you seeing anyone else for other problems or health conditions?___Y___N
Please list the problem/s, date problem/s. began, and provider/s treating you for the condition/s:
_____
Can we send updates to your physician of choice? ___Y___N Name/Location of physician:_____
_____
Past health history—Have you been diagnosed with diabetes?___Y___N___Type I___Type II
Have you been treated for hypertension? ___Y___N
Do you smoke?___Never___Former Smoker___Current/Everyday Smoker___Current Smoker
Medications—What medications are you currently taking? Include vitamins, herbs, minerals….
List the date started, brand/generic name, strength, dosage, frequency, duration, quantity, prescribed by:
_____
_____
_____
Do you have allergies?___Y___N___Food___Environmental___Medication
Type/list/reaction:_____

Assignment & Release:

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for service I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature:_____Date:_____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care of any clinic services that he/she deems necessary in may case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature:_____Date:_____

place label here

Reset Form

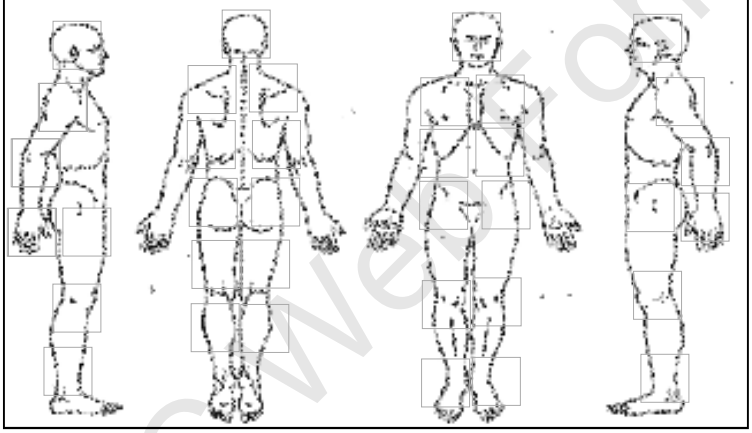
Back Specialists
Sioux Falls, SD 57108

PATIENT HEALTH QUESTIONNAIRE

1. When did your symptoms start? _____ Describe your symptoms and how they began: _____

2. How often do you experience your symptoms?
   - (1) Constantly _____
   - (2) Frequently _____
   - (3) Occasionally _____
   - (4) Intermittently _____

Click with your mouse to indicate where you have pain



3. What option best describes the nature of your symptoms?

(1) Sharp	_____	(1) Shooting	_____
(2) Dull Ache	_____	(2) Burning	_____
(3) Numb	_____	(3) Tingling	_____

4. How are your symptoms changing?
   - (1) Getting Better _____
   - (2) Not Changing _____
   - (3) Getting Worse _____

5. How bad are your symptoms at their

	None										Unbearable
a. worst?	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
b. best?	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)

6. How do your symptoms affect your ability to perform daily activities?

(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
No Complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse? _____

8. What activities make your symptoms better? _____

9. Who have you seen for your symptoms?
   (1) No One (2) Other Chiropractor (3) Medical Doctor (4) Physical Therapist (5) Other

   a. When and what treatment? _____

   b. *What tests have you had for your symptoms and when were they performed?*
   (1) X-rays date: _____ (2) MRI date: _____ (3) CT Scan date: _____ (4) Other date: _____

10. Have you had similar symptoms in the past? (1) Yes (2) No

    a. *If you have received treatment in the past for the same or similar symptoms, who did you see?*
    (1) No One (2) Other Chiropractor (3) Medical Doctor (4) Physical Therapist (5) Other

11. What is your occupation? _____
    (1) Professional/Executive (2) White Collar/Secretarial (3) Tradesperson (4) Laborer (5) Homemaker (6) FT Student (7) Retired (8) Other

    a. If you are not retired, a homemaker, or a student, what is your current work status?
    (1) Full-time (2) Part-time (3) Self-employed (4) Unemployed (5) Off Work (6) Other

12. What do you expect to gain from your visit/treatment (select all that apply)?
    (1) Reduce Symptoms (2) Resume/increase activity (3) Explanation of condition/treatment (4) Learn how to take care of this on my own (5) How to prevent this from occurring again (6) _____

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Back Specialists
Sioux Falls, SD 57108

PATIENT HEALTH QUESTIONNAIRE

What type of regular exercise do you perform? ☐ (1) None ☐ (2) Light ☐ (3) Moderate ☐ (4) Strenuous

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	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Uncoordinated
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss Of Bladder Control
☐	☐	Prostrate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss Of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor

Past	Present	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Caffienated Beverages
☐	☐	Smoking / Tobacco
☐	☐	Drug /Alcohol Dependence
☐	☐	Problems Sleeping
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systematic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV / AIDS

Females Only

☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy
☐	☐	

Other Health Problems/Issues

☐	☐
☐	☐
☐	☐
☐	☐

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

List all of the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

All information referred to or shared in this documentation is true and correct. It reflects my current health status to the best of my ability. I am interested in pursuing health care with **Back Specialists** to achieve relief from my personal discomfort. If my status should change while under the care and supervision I agree to share any and all changes to my health picture with the doctors at **Back Specialists**, in a timely manner.

Patient's Signature _____

BACK SPECIALISTS

IRREVOCABLE ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS, HEALTH INSURANCE BENEFITS AUTO - MEDICAL PAYMENTS, 3RD PARTY PAYOR AND/OR ATTORNEY

To Whom It May Concern:

I, _____, hereby authorize and direct you, my insurance company, 3rd party payor and/or my attorney, to **pay directly to Back Specialists, LLC,** any and all sums as may be due and owing me for services rendered to me by **Back Specialists, LLC,** both by reason of accident or illness, and by reason of any other bills that are due this office. I further direct my insurance company, 3rd party payor and/or my attorney to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, 3rd party payer benefits, or any other insurance benefits and/or monies received and/or owing me from any payments received from any settlement, judgment or verdict on my behalf in an amount equal to any outstanding balance that is owed to **Back Specialists, LLC,** for my treatment. I hereby further irrevocably assign to **Back Specialists, LLC,** any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by **Back Specialists, LLC**, said assignment to be equal to any outstanding balance owed by me to **Back Specialists, LLC**. This is to act as an irrevocable assignment of my rights and benefits to any monies owed or received for my benefit in an amount equal to any outstanding balance owed by me to the **Back Specialists, LLC**. This said assignment is binding under South Dakota Codified Law (SDCL) 57A-9, SDCL 57A-9-102(46) and SDCL 57A-9-309 (5). _____*Initial*

In the event my insurance company, 3rd party payor or attorney are obligated to make payments to me for compensation of any claims, benefits, money owed, settlements and /or judgments, and the insurance company, 3rd party payor, attorney or any other party so obligated refuses to make such payments either upon demand by me or **Back Specialists, LLC,** I hereby assign and transfer to **Back Specialists, LLC** any and all causes of action that I might have or that might exist in my favor against such company and/or party, and authorize **Back Specialists, LLC** to prosecute said cause of action either in my name or in **Back Specialists, LLC** name. I further authorize **Back Specialists, LLC** to compromise, settle or otherwise resolve such claim or cause of action as they see fit. _____*Initial*

In the event I, my attorney, heirs, attorney-in-fact or any other person acting on my behalf, receives monies owed me for compensation of benefits, claims, money owed, settlements and /or judgments, I further agree that an amount equal to that which is owed to **Back Specialists, LLC** by me for any treatment that I receive, shall be placed in trust for the benefit of **Back Specialists, LLC,** for which trust I or anyone that I so designate to be trustee, and **Back Specialists, LLC** being the beneficiary. Said trust will be dissolved upon all amounts due and owing **Back Specialists, LLC** being paid to **Back Specialists, LLC.** _____*Initial*

I understand that I remain personally responsible for the total amounts due to **Back Specialists, LLC** for their services. I further understand and agree that this Assignment and Authorization do not constitute any consideration for **Back Specialists, LLC** to await payments and that they may demand payments from me immediately upon rendering services at their option. _____*Initial*

BACK SPECIALISTS

IRREVOCABLE ASSIGNMENT AND AUTHORIZATION TO PAY
INSURANCE BENEFITS, HEALTH INSURANCE BENEFITS
AUTO - MEDICAL PAYMENTS, 3RD PARTY PAYOR AND/OR ATTORNEY

I authorize **Back Specialists, LLC** to release any information pertinent to my case to any insurance company, including 3rd party payor, adjuster or attorney to facilitate collection under this Assignment and Authorization. I agree that **Back Specialists, LLC** shall be given the Power of Attorney to endorse and/or sign my name on any and all checks for payment of any outstanding bill owed **Back Specialists, LLC**. _____*Initial*

I further understand and agree that if **Back Specialists, LLC** must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse **Back Specialists, LLC,** for all costs of such collection efforts, including but not limited to all court costs and all attorney fees. _____*Initial*

I also understand that interest may be charged on all balances 60 days past due. _____*Initial*

I further direct that this Authorization and Assignment shall be binding upon my legal heirs, successors, assignees, legatees or any other party legally acting on my behalf. _____*Initial*

If submitting via website, the information listed below must be completed onsite.

Patient's Signature _____SS#_____ Date:_____

Guardian or Spouse's
Signature Authorizing Care _____ Date:_____

Attorney Acknowledgement Signature_____ Date:_____

5109 S CROSSING PLACE SIOUX FALLS SD 57108 P: 605.361.1700 F: 605.361.0113

Print Form | Clear Form

BACK SPECIALISTS

Fax to:
(605) 361-0113
No Cover Page Required

Page 1 of ____

GO GREEN - Paperless Notification & Payment Authorization Form

Name (Last, First, MI) **Please Print**		**Date of Birth**

Mailing Address	**City/State/Zip**

TEXT NOTIFICATION - sign up to receive notification of account activity via Text Messages sent directly to your cell phone. Please be aware that standard texting charges may apply, depending upon your cell phone plan.

☐ Send notification of appointment reminders, office closing or cancellation or emergency notifications due to weather.

☐ Cancel text messaging notification.

My cell phone number is: _____ **Mobile Carrier:** _____

EMAIL NOTIFICATION - sign up to have account notifications sent to the email address you designate.

☐ Send notification of appointment reminders, office closing / cancellation or emergency notifications due to weather.

☐ Cancel email notification.

My email address is: _____

CREDIT CARD - sign up to apply monthly payments to my account via my credit card listed below.

☐ **Monthly payment of $**_____

My credit card is: _____ **Security Code:** _____

Account Number: _____ **Expiriation:** _____

By including my email address and/or mobile phone number above, I acknowledge that I will receive appointment reminders, account information and office notifications in an electronic manner. This authority will remain in full force and effect until Back Specialists receives written notification from me of its termination in such time as to afford Back Specialists a reasonable opportunity to act.

Signature _____ **Date** _____

Privacy Disclaimer: These services are provided as a service to patients past and present to provide important information in a timely manner. Your information will not be sold, distributed, or in any other way shared with entities or affiliates outside of Back Specialists.