605 Chiropractic & Wellness
3822 S Western Avenue
Sioux Falls, SD 57105

ABOUT THE PATIENT

Patient Name ____ Today's Date___________ Birthdate _____________ Age________

Address ____ City ____________________________ State ______ Zip ___________

Home Phone (____)______________ Cell Phone (____)______________ Work Phone (____)______________Gender ❑ M ❑ F

Mother's Name ____ DOB ____/____/_____ Mother's Cell (____)__________________

Mother's Occupation _____________________________________ Mother's Employer ____

Father's Name ____ DOB ____/____/______ Father's Cell (____)___________________

Father's Occupation _____________________________________ Father's Employer ____

e-Mail Address ____ Have you been to a chiropractor before? ☐ No ☐ Yes

Name of Family Medical Doctor/Pediatrician ____

- I authorize the doctor or his/her staff to render care as deemed appropriate for me and/or my child.
- I authorize 605 Chiropractic & Wellness to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- 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 after any initial complimentary services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

____ ________________________________

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

EMERGENCY CONTACT INFORMATION

Name ____ Relationship to Patient ____

Home Phone (________)________________________________ Work Phone (_______)____

How did you hear about us? ____

Whom may we thank for referring you? ____

605 Chiropractic & Wellness
3822 S Western Avenue
Sioux Falls, SD 57105

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

Primary Complaint: ______________________________ **When did the problem begin?** ________________

On a Scale of 1 to 10 with 10 being the worst pain and Zero being no pain, rate your above complaints by circling the number:

0 ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

How would you describe it? ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to________________

How long does it last? ____

Have you been seen by anyone in the past for this issue? ❑ Yes ❑ No **If yes, whom did you see?** ____________________

Type of Treatment: ____

Results: ____

What makes it better? ________________________ **What makes it worse?** ________________________

Area of Secondary Complaint: ________________________ **When did the problem begin?** ________________

On a Scale of 1 to 10 with 10 being the worst pain and Zero being no pain, rate your above complaints by circling the number:

0 ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

How would you describe it? ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to________________

How long does it last? ____

Have you been seen by anyone in the past for this issue? ❑ Yes ❑ No **If yes, whom did you see?** ____________________

Type of Treatment: ____

Results: ____

What makes it better? ________________________ **What makes it worse?** ________________________

Third Area of Complaint: ________________________ **When did the problem begin?** ________________

On a Scale of 1 to 10 with 10 being the worst pain and Zero being no pain, rate your above complaints by circling the number:

0 ---- 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10

How would you describe it? ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to________________

How long does it last? ____

Have you been seen by anyone in the past for this issue? ❑ Yes ❑ No **If yes, whom did you see?** ____________________

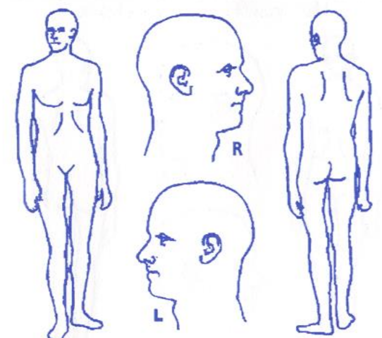
Type of Treatment: ______________________________

Results: ______________________________

What makes it better? ________________________

What makes it worse? ________________________

Please mark all areas of concern.



PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:

R = Radiating B = Burning D = Dull A = Aching N = Numbness

S = Sharp/Stabbing T = Tingling

Are you pregnant? ❑ Yes ❑ No

NOTES: ______________________________

____

____

605 Chiropractic & Wellness
3822 S Western Avenue
Sioux Falls, SD 57105

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities of your daily life.

Activity:	Effect:			
Carry (object/child)	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Sit to Stand	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Movement (of any kind)	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Climb Stairs	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Sitting	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Driving	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Lifting (object/child)	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Standing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Stooping/Bending	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Walking	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Jogging/Running	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Jumping	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Playing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Sleeping	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Washing/Bathing	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Reading	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Concentrating	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Doing the Dishes	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Laundry	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Yard Work/Shoveling	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform
Exercise	___No Effect	___Painful (can do)	___Painful (limits)	___Unable to Perform

Parent or Legal Guardian's Signature: ________________________________ Today's Date:____/____/____

605 Chiropractic & Wellness
3822 S Western Avenue
Sioux Falls, SD 57105

GENERAL HEALTH HISTORY

Patient Name____

Date of Birth _____/_____/______ Age: _________
Birth Height: ______________ Birth Weight: ______________ Current Height: ______________ Current Weight: ________________

Reason for todays visit: ❑ Wellness Check-Up ❑ Injury/Accident ❑ Other

Please mark the conditions that apply to you/your child.

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other ________________________________			

NOTES: ____

____

When did the problem first begin? Date ____/____/____

How did the problem begin? ❑ Sudden Onset ❑ Gradual Onset ❑ Unknown

Have you/your child experienced this problem before? ❑ No ❑ Yes If yes, when? ______________________________

Any bowel or bladder changes since the problem began? ❑ No ❑ Yes If yes, describe: ____________________________

____

Have you/your child been seen any other provider for this problem? ❑ No ❑ Yes If yes, who? ____________________

How long ago were you/your child seen? _______ Days _______ Weeks _______ Months _________ Years

What were the results of the past treatment? ____

How has the problem changed? ❑ Rapidly Improving ❑ Improving, but Progress is Slow ❑ About the Same/No Change ❑ Gradually Worsening ❑ Rapidly Worsening ❑ Symptoms Come and Go

605 Chiropractic & Wellness
3822 S Western Avenue
Sioux Falls, SD 57105

GENERAL HEALTH HISTORY CONTINUED...

1. List any medications being taken:____
2. Number of courses of Antibiotics child has taken in the last 6 mo.______________ Total during lifetime________________
3. Name of Pediatrician and Other Doctors: ____
4. Date of Last Visit _____/_____/_____ Reason:____
5. Name of Obstetrician/Midwife:____
6. Location of Birth: ❑ Hospital ❑ Birthing Center ❑ Home
7. Complications During Pregnancy: ❑ No ❑ Yes Explain:____
8. Ultrasounds During Pregnancy: ❑ No ❑ Yes How Many:__________
9. Medication During Pregnancy / Delivery ❑ No ❑ Yes List:____
10. Cigarette / Alcohol Use during Pregnancy: ❑ No ❑ Yes

PAST HEALTH HISTORY

List any past auto collisions:________________________________ Was any care received?________________

List any past work injuries: ________________________________ Was any care received?________________

List any past sport, recreational, or home injuries____

Please describe any past conditions and treatment received: ____

____

Please list any past hospitalizations and surgeries: ____

____

FAMILY HEALTH 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?____

605 Chiropractic & Wellness
3822 S Western Avenue
Sioux Falls, SD 57105

CONSENT TO TREAT A MINOR

Please print all information.

I, _______________________________, parent or legal guardian of ___________________________________, do hereby request and authorize Dr. Jordan A Fey of 605 Chiropractic & Wellness to perform a chiropractic examination and render chiropractic adjustments and other treatment to my son/daughter: ___________________________. This authorization also extends to all other doctors and office staff members.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

____
Patient's Name (Print)

____
Signature

____
Signature of Parent or Guardian

____
Today's Date

____
Doctor's Name (Print)

____
Doctor's Signature

____
Today's Date

605 Chiropractic & Wellness
3822 S Western Avenue
Sioux Falls, SD 57105

Informed Consent

Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although very rare, minor fractures and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at 605 Chiropractic & Wellness have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____
Patient's Name

______________________________________ ____/____/______ ______________
Parent or Legal Guardian's Signature Date Witness Initials