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

❑ Married ❑ Single ❑ Divorced ❑ Widowed

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

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? □ No □ Yes

Name of Medical Doctor(s)_____

- 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? _____

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

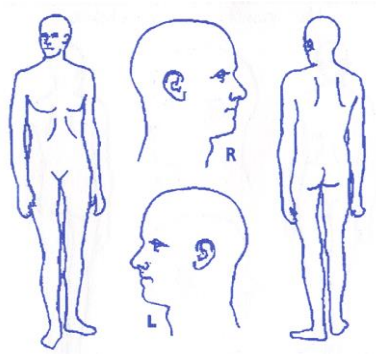
R = Radiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness
S = Sharp/**S**tabbing **T = T**ingling

NOTES: _____
_____
_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



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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
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

Patient Signature: _____ Today's Date:____/____/____

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General Health History

Patient Name_____ *Mark the conditions that apply to you.*

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

List any prescription drugs, over-the-counter medications, and/or supplements you are taking:_____

_____

_____

Please list all doctors you are currently seeing: _____

_____

Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

_____

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?_____

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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 or Authorized Person's Signature	Date	Witness Initials