

Dynamic Spine Chiropractic Health Center

5023 S Bur Oak Pl, Sioux Falls, SD 57108

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 _____
Emergency Contact _____ ph # _____
Relationship to Patient _____
Name of Medical
Doctor(s) _____
Who may we thank for referring you to this office? _____

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

Please Identify the Condition(s) that brought you to this office: Primary: _____
Secondary: _____ Third: _____ Fourth: _____

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:

Primary or Chief Complaint is: 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

Second Complaint is: 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

Third Complaint is: 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

Fourth Complaint is: 0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10

When did the Problem(s) begin? _____

When is the problem at its worst? ____AM ____PM ____Mid-Day ____Late PM

How long does it last? _____

How did the injury happen? _____

Has this been treated by anyone in the past? Y/N

Type of Treatment: _____

Results: _____

Have you Been to a Chiropractor Before? Y/N

What was your experience like? _____

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

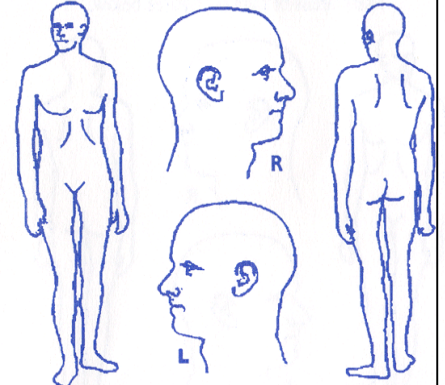
What Relieves your Symptoms? _____

What makes your Symptoms worse? _____

ARE YOU PREGNANT? Y/N

Identify any other injury(s) major or minor, the doctor should know about: _____

Please mark all areas of concern.



Activities of Daily Life

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Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

<u>Activities:</u>	<u>Effect:</u>			
Carry Children/Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Movement of any sort	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lift Children/Objects	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Exercise	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Personal Hygiene (Grooming)	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

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

GENERAL HEALTH HISTORY

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Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- Gall Bladder Trouble
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Other _____

Past Present

- Urinary Problems
- Easy Bruising
- Tobacco Use
- Dental Problems
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Alcohol Use
- ___High or ___Low Blood Pressure
- Stroke History
- High Cholesterol
- TMJ Dysfunction
- Digestive Problems
- Pain all Over
- Tension / Irritability
- Chest Pains
- Heart Pacemaker
- Heart Problems

1. List any medications you are taking: _____

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

3. If you have been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for Currently have, or N for Never Had:
___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo-Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other Serious Conditions: _____

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? _____

FAMILY HEALTH HISTORY

Patient Name _____ Date _____

Please mark **P** for in the **Past**, **C** for **Currently** have, or **N** for **Never**

	Father Age ____	Mother Age ____	Spouse Age ____	Brother(s) Age ____ Age ____	Sister(s) Age ____ Age ____	Children Age ____ Age ____ Age ____
First Name						
Condition						
Allergies						
TMJ (Jaw) Pain						
Arthritis						
Neck Pain						
Scoliosis						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Back Pain						
Frequent Colds/Flu's						
Gassy/Bloating						
Headache						
Sinus Trouble						
Hip Pain						
High Blood Pressure						
Low Energy						
Migraine						
Auto Accidents						
Shoulder Pain						
Numbness/Tingling						
Anxiety						
Heartburn						
Sleeping Problems						
Other:						
Other:						
Other:						

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 risk 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 Dynamic Spine Chiropractic Health Center 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

____/____/____

Regarding: X-rays/Imaging Studies

FEMALES ONLY---Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

The first day of my last menstrual cycle was on ____ - ____ - ____ (Date)

I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure of x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patient or Authorized Person's Signature

Date

____/____/____

A. NOTIFIER:

B. PATIENT NAME:

C. IDENTIFICATION NUMBER:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
___ 98940/98941 CMT – Spinal adjustments ___ E/M 99201-99214 – Evaluations ___ X-Rays ___ Modalities and Therapies ___ 97012 ___ 97010 ___ 97110 ___ 97124	-Medicare does not pay for this service because they consider it “not medically necessary.” -Medicare does not pay for this level of service, this many services, or the length of service. -Medicare does not pay for this service based on diagnosis.	\$50-\$70 \$60-\$200 \$60-\$220 \$20-\$45

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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