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

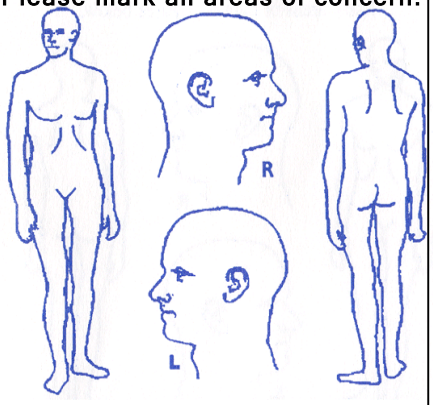
What was your experience like? _____

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

Please mark all areas of concern.



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: _____

_____

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:

Activities:	Effect:			
Carry Children/Groceries	__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 sort	__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
Lift Children/Objects	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Read/Concentrate	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Getting Dressed	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Sleep	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Standing	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Yard Work	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Walking	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Washing/Bathing	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Exercise	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Dishes	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Driving	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Laundry	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform
Personal Hygiene (Grooming)	__No Effect	__Painful (can do)	__Painful (limits)	__Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

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

Pediatric HEALTH HISTORY

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Patient Name_____ ***Mark the conditions that apply to you/your child.***

Date of Birth_____/_____/_____ **Age:**_____

Birth Height:_____ **Birth Weight:**_____ **Current Height:**_____ **Current Weight:**_____

Address _____

City _____ **State** _____ **Zip** _____ **Phone** _____

Mother's Name _____ **DOB** ____/____/____ **Mother's Mobile**_____

Father's Name _____ **DOB** ____/____/____ **Father's Mobile**_____

Pediatrician/Family MD _____ **City/State** _____

Last Visit: ____/____/____ **Reason for visit:** _____

Who is responsible for this bill? _____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please Explain: _____

If your child is experiencing Pain/Discomfort please identify where and for how long:

_____

_____

When did the Problem first begin? Date ____/____/____ ____Unknown ____Gradual ____Sudden

Ever had this problem before? ____No ____Yes If yes, when? _____

Any bowel or bladder problems since this problem began? If yes, describe: _____

_____

Have you seen any other doctors for this problem? ____No ____Yes If Yes, Who? _____

How long ago? _____Days ____Weeks ____Months ____Years

What were the results of past treatment? _____

How is the problem now? Rapidly Improving Improving Slowly About the Same Gradually worsening On and off

List any medications taken: _____

PAST HISTORY

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

13. List any past falls bumps bruises: _____ **Was any care received?**_____

14. List any past sport, recreational, or home injuries:_____

15. Please describe any past conditions and treatment received:

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

I understand that I am directly and fully responsible to Dynamic Spine Chiropractic Health Center for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorizes this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

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