

Dynamic Spine Chiropractic Health Center

4900 South Technopolis Drive, Sioux Falls, SD 57106

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

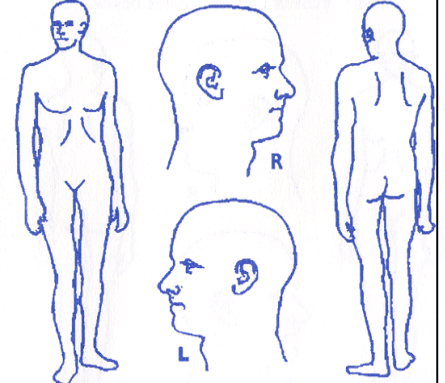
What Relieves your Symptoms? _____

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:** ____/____/____

Pediatric HEALTH HISTORY

Dynamic Spine Chiropractic Health Center
4900 South Technopolis Drive, Sioux Falls, SD 57108

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

____/____/____