810 Mountain View Road, Rapid City, SD 57702

Patient Information

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Sex: M/F Home Phone: _____ Cell: _____

Work Phone: _____ Occupation: _____

Name or spouse or nearest relative: _____ Phone: _____

Referred to this office by: _____ Payment for services will be by: _____

Email address for appointment reminders: _____

Would you like your email included on our wellness newsletter list? _____

Emergency Contact: _____ Marital Status: _____

Major Complaint Information

What is your major complaint? _____

When did the symptoms begin? _____

If this is an injury, describe what happened: _____

Rate the severity of your symptoms on a scale of 0-10, with 0 representing no pain and 10 representing the most severe pain. My pain is currently on a scale of 0-10: _____ What is the least intense the symptoms has been on a scale of 0-10: _____ What is the most intense the symptom has been on a scale of 0-10: _____.

Have you experienced these symptoms before? _____ If so, when? _____

What aggravates the symptoms?

_____

What improves the symptoms?

_____

Have you seen a doctor for this condition? _____ If so, name of doctor: _____

Does this condition interfere with your sleep?

_____

In what position do you sleep?

_____

**Secondary Complaint Information**

1. _____

2. _____

3. _____

History

Have you been treated by a health care professional in the last year for a health condition? _____

If so, please describe the condition:

_____

Date of last physical exam:

_____

Height: _____ Weight: _____ High or low blood pressure: _____

Surgical History:

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Accident History:

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Are allergic to any medications?

_____

Do you take any medications?

_____

_____

_____

Female: Are you pregnant?

_____

Have you been seen by a chiropractor before? _____ Name: _____

## Additional Complaints/Family History

Please circle all additional complaints that you have at this time. If a family member has or has had any of the following please describe:

Loss of Concentration

Eyes Sensitive to Light

Memory Loss

Heavy Feeling of Head

Headaches

Dizziness

Ringing in Ears

Loss of Balance

Loss of Smell

Loss of Taste

Pain Behind Eyes

Fainting

Palpitation

Neck Stiffness

Neck Motion Restricted

Upper Back Pain / Stiffness

Mid Back Pain / Stiffness

Right / Left Shoulder Pain

Right / Left Arm Pain

Pins & Needles Arms / Legs

Right / Left Leg Pain

Low Back Pain/Stiffness

Sinus Trouble

Nervousness

Chest Pain

Shortness of Breath

Irritable

Anxiety

Depression

Insomnia

Fatigue

Excess Perspiration

Digestive Trouble

Nausea

Vomiting

Diarrhea

Constipation

Cold Hands

Cold Feet

Jaw pain

Hypertension

Diabetes

Convulsions

Allergies: Please List_____

Vision Problems

Anemia

Heart Disease

Arthritis

HIV (Aids)

Other (Please List)

_____

_____

Please Specify Location:

Numbness _____

Swelling _____

Cuts _____

Bruising _____

Areas on Interest - please circle if you would like more information

Nutritional Supplements Acupuncture Biofeedback

BrainCore Neurofeedback (helps to alleviate the symptoms of neurological conditions such as ADD/ADHD, Autism, Depression, Anxiety, Insomnia, PTSD, and many more).

Chiropractic for children and/or pregnancy Massage Reiki

Lymphatic Drainage Therapy Hair Mineral Analysis Orthotics

Advanced Allergy Therapeutics (helps to alleviate the symptoms related to numerous allergies).

Authorization & Assignment

I authorize Bahr Chiropractic Wellness Center, LTD, to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred to me.

I authorize the direct payment to you of any sum I now or hereafter owe your by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for you services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be in all or part of what is due) I personally owe.

I, the undersigned do hereby appoint Bahr Chiropractic Wellness Center, LTD, authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned clinic.

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and me. I clearly understand and agree that all services rendered me are charge directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs, collections, attorney's fee or court cost required to collect my bill.

Date: _____ Patient Signature:

_____