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: _____

Review of Systems

Have you had any of the following **pulmonary (lung-related) issues?** □ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures? □ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues? □ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures? □ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures? □ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues? □ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues? □ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues? □ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues? □ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues? □ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

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:

_____