A Unruh Chiropractic Clinic

600 N. Western Avenue – Sioux Falls, SD 57104-2029

Phone: (605) 332-1962

Patient Information

Name: (First, Middle Initial, Last): _____ Date of Birth: _____

Address: _____ (City, State, and Zip): _____

Social Security #: _____ - ____ - _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Mobile Carrier: _____ Preferred Name: _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-Time Student ☐ Full-Time Student ☐ Other

E-Mail: _____ Race: _____ Ethnicity: _____

Employment Information (If Applicable)

Employer: _____ Work Phone: _____

Address: _____ (City, State, and Zip): _____

Responsible Party Information (If Applicable)

Name: (First, Middle Initial, Last): _____ Date of Birth: _____

Address: _____ (City, State, and Zip): _____

Social Security #: _____ - ____ - _____ Responsible Party's Phone #: _____ Relationship to Patient:_____

Occupation: _____ Employer: _____ Employer Phone #: _____

Spouse Information (If Applicable)

Name: (First, Middle Initial, Last): _____ Date of Birth: _____

Address: _____ (City, State, and Zip): _____

Social Security #: _____ - ____ - _____ Employer: _____ Employer Phone #: _____

Relative to Contact in Case of Emergency

Name : _____ Phone: _____

Address: _____ (City, State, and Zip): _____

Is Your Illness of Injury Related to Any of the Following?

☐ No ☐ Employment ☐ Auto Accident (State of Auto Accident): _____

If Employment related, has the employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

How Were You Referred to Our Office?

☐ By an Attorney ☐ By a Doctor ☐ By a patient ☐ Yellow Pages ☐ Other: _____

Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care that may include diagnostic procedures, examination, and treatment. I hereby assign, and transfer, and set over to A. Unruh Chiropractic Clinic all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

SOCIAL HISTORY

Check the boxes and fill in.

Current weight: _____ Have you recently lost or gained weight? ☐ YES ☐ NO

Mental Work ☐ Heavy ☐ Moderate ☐ Light Hours per day: _____

Physical Work ☐ Heavy ☐ Moderate ☐ Light Hours per day: _____

Exercise ☐ Heavy ☐ Moderate ☐ Light Hours per week: _____ Type: _____

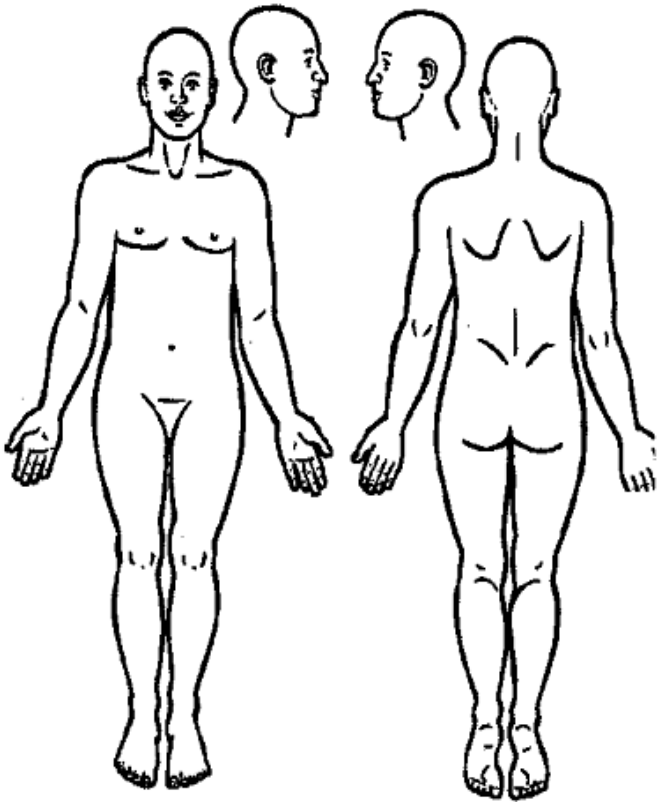
Smoking ☐ Current ☐ Previous Packs/Day: _____ No. of years: _____

Alcohol Beer/Week: _____ Liquor/Week: _____ Wine/Week: _____ No. of years: _____

Caffeine (Coffee, Tea, Cola) Cups/Day: _____ No. of Years: _____

Aspirin No./Day: _____ No. of years: _____ Others: _____

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT.



Use the appropriate letter shown for each symptom:

Aches – A Burning – B Pins/Needles – P

Cramps – C Stabbing – S Numbness – N

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain): _____

_____ _____

Signature of Patient/Insured/Guardian Date

PATIENT CASE HISTORY

Describe Major Complaint: _____

Began when? _____ Describe how this began: _____

_____

_____

Grade Intensity/Severity of Complaint: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

Quality of the pain: ☐ Sharp ☐ Stabbing ☐ Burning ☐ Achy ☐ Dull ☐ Stiff & Sore Other: _____

How frequent is the complaint/pain present? ☐ Off & On ☐ Constant Other: _____

Does this complaint radiate/ shoot to any areas of your body? ☐ No ☐ Yes (Describe): _____

Head – Base of skull / Forehead / sides-temple R / L / both Leg – Hip / thigh-knee / calf / foot-toes R / L / both

Arm - Across shoulder / Elbow / head-fingers R / L / both Other Areas: _____+_____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? (Describe): _____

For this CURRENT condition, have you:

- Received any other treatment? None / DC / MD / PT / Massage / ER / Other: _____ Where? _____
- Had any previous surgery if interventions in this area? (Describe): _____
- Taken any medications? OTC / Prescriptions: _____
- Had any diagnostic testing? X-Rays / MRI / CT / Other: _____ When & Where? _____

Describe any secondary complaints: _____

Medications:

Allergies to Medications: NONE (List): _____

_____

Current Medications: NONE

(Already have a list? We can make a copy)

_____

_____

_____

_____

Past Health History: (Please list any past…)

Surgeries – Date, Type, and Reason: NONE

_____

_____

_____

_____

Major Injuries/Traumas: NONE _____

_____

_____

Major Hospitalizations: _____

_____

Family Health History: (Please mark N/A if not relevant)

List relevant major health problems of immediate relatives: _____

_____

_____

Deaths in immediate family: (Cause and at what age?)

_____

_____

Social & Occupational History:

Level of education completed: _____

High School / Some college / College grad / Post Grad

Lifestyle: (hobbies, rec. activities, exercise, diet, work, vitamins) _____

_____

_____

_____

Are you currently experiencing any of these symptoms? (*Check all that apply*)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)
__ Recent Weight Change
__ Fever
__ Fatigue
__ *None in this Category*

Musculoskeletal:
__ Low Back Pain
__ Middle Back Pain
__ Neck Pain
__ Arm Problems _____
__ Leg Problems _____
__ Painful Joints
__ Stiff/Swollen Joints
__ Sore/Weak Muscles or Joints
__ Muscle Spasms/Cramps
__ Broken Bones _____
__ Other: _____
__ *None in this Category*

Neurological:
__ Numbness or tingling sensations
__ Loss of feeling
__ Dizziness or light headed
__ Frequent or recurrent headaches
__ Convulsions or seizures
__ Tremors
__ Stroke
__ Ever had a head injury?
__ Ever been in an auto accident?
__ Other: _____
__ *None in this Category*

Mind/Stress:
__ Nervousness
__ Depression
__ Sleep Problems
__ Memory Loss or Confusion
__ Other: _____
__ *None in this Category*

Genitourinary:
__ Sexual Difficulty
__ Kidney Stones
__ Burning/Painful Urination
__ Change in force/strain - Urination
__ Frequent Urination
__ Blood in Urine
__ Incontinence or Bed Wetting
__ Other: _____
__ *None in this Category*

Gastrointestinal:
__ Loss of Appetite
__ Blood in Stool
__ Change in Bowel Movements
__ Painful Bowel Movements
__ Nausea or Vomiting
__ Abdominal Pain
__ Frequent Diarrhea
__ Constipation
__ Other: _____
__ *None in this Category*

Cardiovascular & Heart:
__ Chest Pains
__ Rapid or Heartbeat changes
__ Blood Pressure Problems
__ Swelling of hands, ankles or feet
__ Heart Problems
__ Other: _____
__ *None in this Category*

Respiratory:
__ Difficulty Breathing
__ Persistent Cough
__ Coughing Blood
__ Asthma or Wheezing
__ Lung Problems
__ Other: _____
__ *None in this Category*

Eyes & Vision:
__ Wear contacts/glasses
__ Blurred or double vision
__ Glaucoma
__ Eye disease or injury
__ Other: _____
__ *None in this Category*

Ears, Nose, & Throat:
__ Bleeding gums/mouth sores
__ Bad breath or bad taste
__ Dental Problems
__ Swollen throat or voice change
__ Swollen glands in neck
__ Ringing in ears
__ Ear – aches/ringing/drainage
__ Sinus/Allergy problems
__ Nose Bleeds
__ Hearing Loss
Other: _____
__ *None in this Category*

Endocrine, Hematologic, & Lymphatic:
__ Thyroid problems
__ Diabetes
__ Excessive thirst or urination
__ Cold Extremities
__ Heat or cold intolerance
__ Change in hat or glove size
__ Dry Skin
__ Glandular or hormone problem
__ Swollen Glands
__ Anemia
__ Easily bruise or bleed
__ Phlebitis
__ Transfusion
__ Immune System Disorder
__ Other: _____
__ *None in this Category*

Skin & Breasts:
__ Rash or itching
__ Change in skin color
__ Change in hair or nails
__ Non-Healing Sores
__ Change of appearance of a mole
__ Breast Pain
__ Breast Lump
__ Breast Charge
__ Other: _____
__ *None in this Category*

Women Only:
Are you pregnant?
__ Yes – *Due Date* ___/___/_____
__ No – *Last Menstrual Period* ___/___/_____
__ Infertility
__ Painful or irregular periods
__ Vaginal Discharge
__ Other: _____
__ *None in this Category*

Pregnancies with outcome & date:
_____
_____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and herby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services in accordance with this state's statutes.

Patient or Guardian Signature: _____ **Date:** _____/_____/_____

A.UNRUH CHIROPRACTIC CLINIC

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby consent to the performance of diagnostic test(s) and the administration of procedures and other chiropractic treatment in the management of my health condition(s).

Chiropractic treatment, like all other medical procedures and treatment does have an inherent (but very small) risk of bodily harm. The serious risk associated with chiropractic procedures, particularly with Chiropractic Manipulative Therapy (CMT), or spinal "adjustment" is extremely rare. Some of the known risks are identified below.

Temporary soreness or increased symptoms or pain: It is not uncommon for patients to experience temporary soreness, brief increase in symptoms, or brief increase in pain following chiropractic treatment procedures and CMT.

Dizziness, nausea, or flushing: These symptoms are relatively rare. These are usually temporary and resolve without any intervention. It is important to notify your chiropractor if you experience these symptoms during or following your care.

Fracture: Rib fractures can occur but are extremely rare. It is important to notify your D.C. if you have been diagnosed with or are being treated for osteoporosis, if you have previously had a spinal compression fracture or if you have previously been diagnosed with any "insufficiency" fractures or delayed fracture repair. If you do have any bone weakening disease, your D.C. will modify your treatment or recommend some other type of treatment to minimize your risk of injury or fracture.

Disc herniation or prolapse: Disc bulges or disc herniation's are common – even in patients not experiencing the typical symptoms of a "pinched nerve" and may be present at the time of your treatment. It is important to let your D.C. know about any change in sensation, weakness or if your symptoms change or worsen.

Stroke: A certain type of extremely rare stroke ("vertebral artery dissection" or vertebral artery stroke) is associated with chiropractic care. Recent research indicates the risk of stroke following chiropractic care is virtually the same as the risk of stroke following traditional medical care. With this condition patients often have neck pain or headache requiring treatment by a healthcare professional. There is no conclusive evidence that CMT is specifically related to the cause of stroke.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science and I acknowledge that a guarantee or promise of cure can be given as to the results or outcome of my care.

I have read or have had this read to me this Informed Consent document. I have discussed or been given the opportunity to discuss any questions or specific concerns with my D.C. and have had these answered to my satisfaction prior to my signing this Informed Consent document. I have made my decision to accept these risks and continue care voluntarily and of my own free will.

Patient's Name (Please PRINT legibly) Date

Doctor of Chiropractic Signature, D. C. Date

Patient's Signature/Legal Guardian Date