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

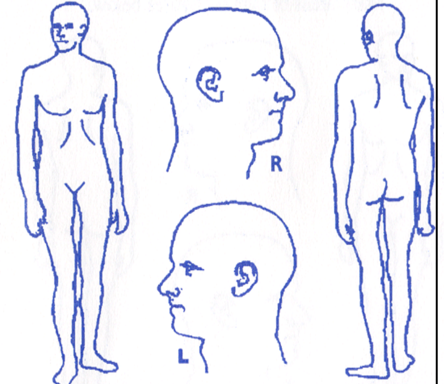
What was your experience like? _____________________________________

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:**____/____/____

GENERAL HEALTH HISTORY

Dynamic Spine Chiropractic Health Center
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Patient Name_______________________________________ *Mark the conditions that apply to you.*

Past	Present	
❑	❑	Headaches
❑	❑	Migraines
❑	❑	Shortness of Breath
❑	❑	Allergies / Asthma
❑	❑	Medication Side Effects
❑	❑	Diabetes
❑	❑	Hands or Feet cold
❑	❑	Muscle aches
❑	❑	Trouble Walking
❑	❑	Leg / Foot Numbness
❑	❑	Fainting
❑	❑	Gall Bladder Trouble
❑	❑	Ringing in Ears
❑	❑	Ear Problems
❑	❑	Sleeping Problems
❑	❑	Vision Problems
❑	❑	Thyroid Problems
❑	❑	Liver Disease
❑	❑	Kidney Problems
❑	❑	Light Bothers Eyes
❑	❑	Urinary Problems
❑	❑	Easy Bruising
❑	❑	Tobacco Use
❑	❑	Dental Problems
❑	❑	Fibromyalgia
❑	❑	Blood Thinner use
❑	❑	HIV Positive
❑	❑	Cancer
❑	❑	Depression
❑	❑	Alcohol Use
❑	❑	___High or ___Low Blood Pressure
❑	❑	Stroke History
❑	❑	High Cholesterol
❑	❑	TMJ Dysfunction
❑	❑	Digestive Problems
❑	❑	Pain all Over
❑	❑	Tension / Irritability
❑	❑	Chest Pains
❑	❑	Heart Pacemaker
❑	❑	Heart Problems
❑	❑	Other ____

1. List any medications you are taking: ____
____
2. Please list all doctors you are currently seeing:
____
3. If you have been diagnosed with any of the following conditions, please indicate with a P for in the Past, C for Currently have, or N for Never Had:
___ Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo-Arthritis ___Diabetes ___Cerebral Vascular ___Other Serious Conditions: ____________________

PAST HISTORY

4. List any past auto collisions:________________________Was any Care Received? __________
5. List any past work injuries: ________________________Was any Care Received? __________
6. List any past sport, recreational, or home injuries____________________________________
7. Please describe any past conditions and treatment received: __________________________
____
8. Please list any past hospitalizations and surgeries: _______________________________
____

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 know?____

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