Sturgis CHIROPRACTIC
Specific Chiropractic

824 1st Street, Sturgis, SD 57785
P: 605-347-4003 **F**: 605-347-6929 **sturgischiropractic@gmail.com**

PATIENT INFORMATION

First Name: _____ M. I. _____
Last Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
*Cell Phone: _____
*Email: _____
Sex: ☐ M ☐ F Age: _____ Birthdate: _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Employer/School: _____
Occupation: _____

SPOUSE INFORMATION

Spouse's Name: _____
Spouse's Employer: _____
Spouse's Occupation: _____

IN CASE OF EMERGENCY, CONTACT

Name: _____
Relationship: _____
Contact Number: _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOU?

What brings you in today? _____
_____

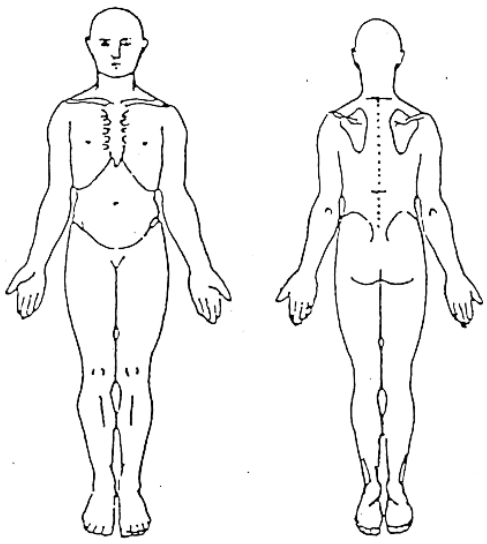
If you are already experiencing a symptom, explain: _____

How intense are your symptoms 0-10? (circle)

0 1 2 3 4 5 6 7 8 9 10

NO SYMPTOMS — INTENSE SYMPTOMS

Please circle areas where you have pain or other symptoms:



Describe your symptoms: (check where appropriate)

☐ Numbness ☐ Sharp
☐ Tingling ☐ Shooting
☐ Stiffness ☐ Burning
☐ Dull ☐ Throbbing
☐ Aching ☐ Stabbing
☐ Cramping ☐ Swelling
☐ Nagging ☐ Other: _____

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IMPACT OF YOUR SYMPTOMS

How is this symptom/condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐		☐	☐	☐	☐

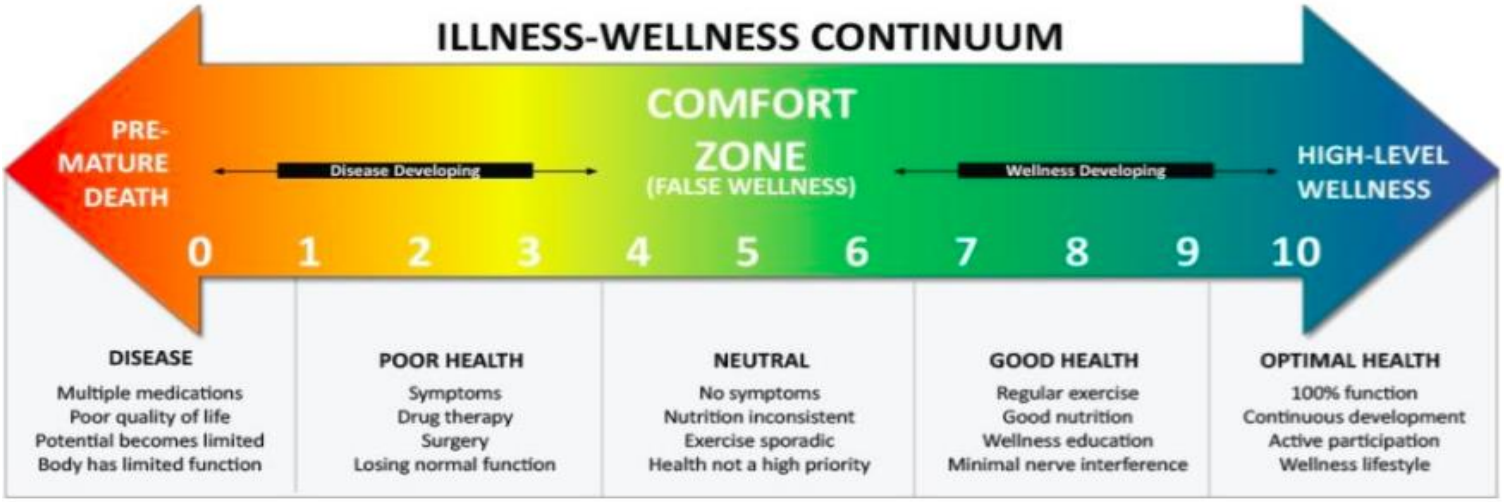
How committed are you to correcting this issue 0-10? (circle)

0 1 2 3 4 5 6 7 8 9 10

0 NOT COMMITTED

10 VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE: _____

SHORT TERM: _____

LONG TERM: _____

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CHILDREN & PREGNANCY

How many children do you have? _____

Children's ages? _____

Children's health concerns? _____

_____

_____

Are you currently pregnant?

☐ No ☐ Yes, I'm due: _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____

_____

HEALTH & ILLNESS HISTORY

Please check any box beside any condition that you have or have had.

- ☐ ADHD/ADD
- ☐ Focus/Memory Issues
- ☐ Uncoordinated
- ☐ Seizures
- ☐ Dizziness
- ☐ Stroke
- ☐ Facial Paralysis
- ☐ Difficulty with Speech
- ☐ Hand Trembling
- ☐ Loss of Sensation
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Muscle Cramps
- ☐ Muscle Twitching
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Shoulder Pain
- ☐ Arm/Hand Pain
- ☐ Ankle/Foot/Knee Pain
- ☐ Stiff Neck
- ☐ Neck Soreness
- ☐ Pain/Numbness in Arms/Hands
- ☐ Pain/Numbness in Legs/Feet
- ☐ Angina
- ☐ Heart Murmur
- ☐ Hypertension
- ☐ Anemia
- ☐ Asthma/Difficulty Breathing
- ☐ Tonsilitis/Strep Throat
- ☐ Sinus Congestion
- ☐ Sinus Infections
- ☐ Ear Ringing
- ☐ Earache
- ☐ Diabetes
- ☐ Thyroid Condition
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Hair Changes
- ☐ Autoimmune Dx
- ☐ Allergies
- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty Swallowing
- ☐ Abdominal Pain
- ☐ Heartburn/Indigestion
- ☐ Diarrhea/IBS/Crohn's Dx
- ☐ Constipation
- ☐ Menstrual Cramps
- ☐ Reproductive Issues
- ☐ Endometriosis
- ☐ Breast Changes
- ☐ Bladder Trouble
- ☐ Urinary Trouble
- ☐ Weak Grip
- ☐ Cancer: _____
- ☐ Other: _____

_____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you interested in Nutritional/Lifestyle Coaching? _____ If yes, circle below:
Inflammation/Gut Health/Cardiovascular/Hormonal/Immune System/Weight Loss/Sleep, Other: _____

Wellness Goals you would like to achieve: _____

Please READ AND INITIAL the following:

Acknowledgement of Receipt of Notice of Privacy Practices: I have read/acknowledged the Notice of Privacy Practices for Protected Health Information. Notice of Privacy Practices is available at the front desk upon request.

Initials: _____

Payment Policy: I acknowledge I am financially responsible for all charges incurred at Sturgis Chiropractic, P.C. **It is the policy of this office that payment be made at the time of service for all services rendered.** If the incorrect insurance is provided at the time of service, these visits will be considered self-pay. If care is ceased, any remaining balance must be paid in full. **A credit/debit card must be on file and will be run for fees at the time of service or the remaining account balance.**
If the chiropractic services received are deemed maintenance/wellness/corrective care, the visits will not be submitted to insurance and the patient is responsible for the associated fees. Payment delinquency over 180 days will result in an additional 30% collection fee.

Initials: _____

Insurance Assignment: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. If the incorrect insurance is provided at the time of service, these visits will be considered self-pay.
If the chiropractic services received are deemed maintenance/wellness/corrective care, the visits will not be submitted to insurance and the patient is responsible for the associated fees. **Initials: _____**

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

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including chiropractic adjustments, examinations, various modes of physiotherapy, shockwave treatment, diagnostic x-rays, massage therapy, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Sturgis Chiropractic and /or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers, including those working at the clinic or office.

I will discuss with the Sturgis Chiropractic provider and/or with other office or clinic personnel the nature and purpose of the procedures, if I choose to do so.

I understand, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the Sturgis Chiropractic provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor/health care provider to exercise judgment during the procedure which the doctor/health care provider feels at the time, based upon the facts then known, is in my best interests.

I further understand that treatment is designed to improve health. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final, and no refunds will be issued. I further understand that there are treatment options available for my condition, these treatment options include, but not limited to self-administered, over the counter analgesics, bracing, rest or medical care. I understand I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I will ask the doctor/health care provider questions about its consent if I have any, and by signing below I agree to the above-named procedures. I consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name of Parent/Guardian: _____ Relationship to Patient: _____

Parent/Guardian Signature: _____

Date: _____