BLACK HILLS
HEALTH & WELLNESS CENTER

PERSONAL HISTORY

Date_____Social Security No._____
Name (First, Middle, Last) _____Nickname Preferred_____
Street Address_____City _____State____Zip_____
Home Phone_____Business Phone _____
Cell Phone _____Email _____
Billing Address_____City_____State_____Zip_____
Birth date_____Age_____Sex: M F
Business/Employer_____Type of Work_____
Check One: ___Married ___ Single ___Widowed ___Divorced ___Separated No. of Children_____
Name of Emergency Contact_____Relationship_____Phone_____
Address_____City_____State_____Zip_____
Who is responsible for your bill _____
Whom may we thank for referring you to us: _____

INSURANCE INFORMATION

Date_____Patient's Name_____
Insured's Name_____**Relationship**_____**Date of Birth**_____
Address_____
Employer_____Work Phone_____
Social Security Number_____
Insurance Co. Name _____
Insurance Co. Address _____
Insurance Co. Phone_____Policy No. _____Group #_____
IS CLAIM RELATED TO EMPLOYMENT _____**Yes** _____**No**
Date of Accident _____Description_____
_____
Employer's Name_____
Has Accident Report been filed with Employer _____Yes _____No
IS CLAIM RELATED TO AUTO ACCIDENT _____**Yes** _____**No**
Responsible Party's Insurance Company's Name and Address_____
_____Policy No_____
Date of Accident_____Attorney's Name_____
OTHER ACCIDENTS PLEASE DESCRIBE_____
_____

TO THE NEW PATIENT
Outline of Procedure for New Patients

1. **STEP ONE**: All new patients are requested to fill out a personal health/history questionnaire.

2. **STEP TWO**: Your first consultation with a doctor to discuss your health problems.

3. **STEP THREE**: Diagnostic chiropractic, orthopedic and neurological examination procedures to determine if chiropractic care is appropriate for your condition.

4. **STEP FOUR**: The doctor will advise you as to need of additional procedures such as laboratory and x-ray tests, if necessary.

5. **STEP FIVE**: If your case requires immediate attention, emergency first aid will be administered.

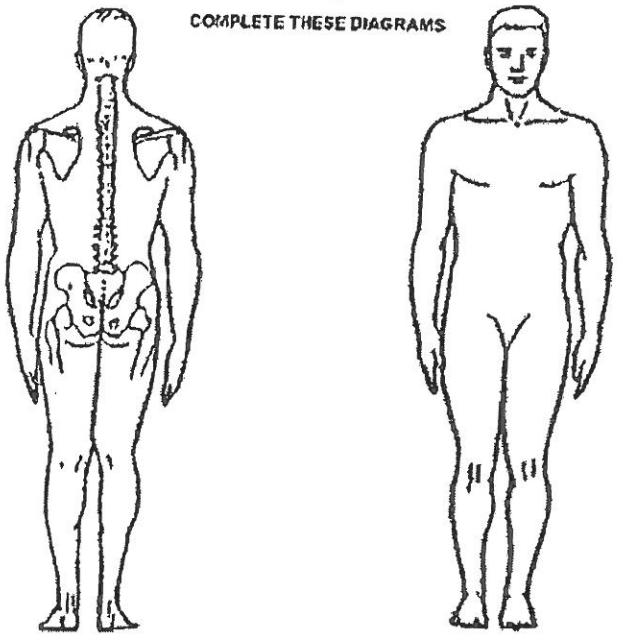
6. **STEP SIX:** You will be advised as to a time you can return for your "Report of Findings" when your doctor will inform you as to your examination results and whether or not your case has been accepted. You will also be advised concerning financial arrangements and insurance coverage where appropriate.

7. **STEP SEVEN**: After you return and receive your "Report of Findings" your recommended treatment program will be explained to you

8. **STEP EIGHT**: Treatments will begin and continue as scheduled until you condition has been fully corrected, or until the maximum possible improvement has been obtained.

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT
(Please describe only your major problem)

How did this condition develop? (What caused it? How did it start?) _____

Have you ever had this problem or similar problem before? If yes, please explain _____

Have you ever received any treatment for this condition? If yes, where and when, and what were your results? _____

Has this problem been getting better, worse or staying the same? _____

HEALTH HISTORY

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Identify the major cause of stress (eg., changes in job, work, residence or finances, legal problems):
_____

Do you consider yourself: __underweight __overweight __just right Your weight today: _____
Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____
Is your job associated with potentially harmfull chemicals (eg., pesticides, radioactivity, solvents) or health and/or life threatening activities (eg., fireman, etc.)? _____
What are your current health goals? _____
_____
_____

MEDICATION YOU NOW TAKE_____
_____

FEMALES ONLY: When was your last period?_____Are you pregnant? ___Yes ___No ___Maybe

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History
__Arthritis
__Allergies/hay fever
__Asthma
__Alcoholism
__Alzheimer's Disease
__Autoimmune disease
__Blood pressure problems
__Bronchitis
__Cancer
__Chronic fatigue syndrome
__Carpal tunnel syndrome
__Cholesterol, elevated
__Circulatory problems
__Colitis
__Dental problems
__Depression
__Diabetes
__Diverticular diseases
__Drug addiction
__Eating disorder
__Epilepsy
__Emphysema
__Eye, ear, nose, throat problems
__Environmental sensitivities
__Fibromyalgia
__Food intolerance
__Gastroesophageal reflux disease
__Genetic disorder
__Glaucoma
__Gout
__Heart disease
__Infection, chronic
__Inflammatory bowel syndrome
__Kidney or bladder disease
__Learning disabilities
__Liver or gallbladder disease (stones)
__Mental Illness
__Mental retardation
__Migraine headaches
__Neurological problems (Parkinson's, paralysis)
__Sinus problems
__Stroke
__Thyroid trouble
__Obesity
__Osteoporosis
__Pneumonia
__Sexually transmitted disease
__Seasonal affective disorder
__Skin problems
__Tuberculosis
__Ulcer
__Urinary tract infection
__Varicose veins
__Other_____

Medical (Men)
__Benign prostatic hyperplasia
__Prostate cancer
__Decreased sex drive
__Infertility
__Sexually transmitted disease
__Other_____

Medical (Women)
__Menstrual Irregularities
__Endometriosis
__Infertility
__Fibrocystic Breasts
__Fibroids/ovarian cysts
__Premenstrual syndrome
__Breast cancer
__Pelvic Inflammatory disease
__Vaginal infections
__Decreased sex drive
__Other_____

Family Health History
(Parents and Siblings)
__Arthritis
__Asthma
__Alcoholism
__Alzheimer's disease
__Cancer
__Depression
__Diabetes
__Drug addiction
__Eating disorder
__Genetic disorder
__Glaucoma
__Heart disease
__Infertility
__Learning disabilities
__Mental Illness
__Mental retardation
__Migraine headaches
__Neurological disorders (Parkinson's, paralysis)
__Obesity
__Osteoporosis
__Stroke
__Suicide
__Other_____

Health/Habits
__Tobacco
__Cigarettes: #/day____
__Alcohol
__Caffeine
__Coffee: #6oz cups/day
__Soda w/caffeine: # cans/day_____
__Other sources
__Water: # glasses/day_____

Exercise
__5-7 days/wk
__2-4 days/wk
__1-2 days/wk

Eating Habits
__One meal/day
__Two meals/day
__Three meals/day
__Graze (small frequent meals)
__Generally eat on the run
__Eat constantly whether hungry or not

Current Supplements – List
_____
_____
_____
_____
_____
_____
_____

I Would Like To:

ENERGY-VITALITY
__Feel more vital
__Have more energy
__Be less tired after lunch
__Sleep better
__Be free of pain
__Not be dependent on over-the-counter medications (like anti-histamines, sleep aides)
__Stop using laxatives and stool softeners
__Improve sex drive

BODY COMPOSITION
__Lose weight
__Burn more body fat
__Be stronger
__Have better muscle tone
__Be more flexible

STRESS, MENTAL, EMOTIONAL
__Learn to reduce stress
__Think more clearly and be more focused
__Improve memory
__Be less depressed
__Be less moody
__Be less indecisive

LIFE ENRICHMENT
__Reduce my risk of degenerative disease
__Slow down accelerated aging
__Maintain a healthier life longer
__Change from a "treating-illness" orientation to creating a wellness lifestyle

---

Authorization to Release Information

Patient Name:_____Date of Birth:_____
(also list maiden name/other names used)

I hereby request and authorize: Black Hills Health & Wellness Center
1220 Mt. Rushmore Rd, Ste 1
Rapid City, SD 57701

To Disclose information to:

Name _____Relationship_____

Address_____

City/State/Zip_____

Information to be disclosed includes:

_____Billing information _____Appointments
_____Pre certification/authorization _____Other, specify:

_____Date:_____
Signature of Patient

_____Date:_____
Signature of Legal Representative/Relationship

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

BLACK HILLS
HEALTH & WELLNESS CENTER
1220 Mt. Rushmore Road, Suite #1
Rapid City, SD 57701

Gregory S. Scherr, D.C.
Stephen L. Gullikson, D.C.
Jayme G. Scherr, D.C.

(605) 341-8649
(605) 341-7500
Fax (605) 341-7903

Informed Consent for Chiropractic Treatment and Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor or intern, affiliated with BH Health and Wellness Center.

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above, and allow the doctor or intern, affiliated with BH Health and Wellness Center to perform such. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient's Name (Please Print) **Date**

_____

Patient or Guardian's Signature

BLACK HILLS
HEALTH & WELLNESS CENTER
1220 Mt. Rushmore Road, Suite #1
Rapid City, SD 57701

Gregory S. Scherr, D.C.
Stephen L. Gullikson, D.C.
Jayme G. Scherr, D.C.

(605) 341-7500
(605) 341-8649
Fax (605) 341-7903

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received the Black Hills Health and Wellness Center Notice of Privacy Practices for protected health information.

Date: _____ **Name of Patient:** _____

_____
Signature of Patient / Personal Representative

BLACK HILLS
HEALTH & WELLNESS CENTER

1220 Mt. Rushmore Road
Rapid City, SD 57701

Gregory S. Scherr, D.C.
Stephen Gullikson, D.C.
Jayme Scherr, D.C.

(605) 341-8649
(605) 341-7500
Fax (605) 341-7903

IRREVOCABLE ASSIGNMENT OF HEALTH-CARE INSURANCE RECEIVABLES UNDER ARTICLE 9 – SECURED TRANSACTIONS – UNIFORM COMMERCIAL CODE (SDCL CHAPTER 57A-9) and AUTHORIZATION TO RELEASE HEALTH-CARE INFORMATION

_____

I, the undersigned, do hereby irrevocably assign, set over and grant a perfected security interest pursuant to the provisions of SDCL 57A-9 **TO Black Hills Health & Wellness Center** in and to any and all health-care insurance receivables due the undersigned as a result of health-care services provided me by the above named doctor or clinic by reason of accident, illness or any other health related condition. This is an irrevocable assignment of my rights and benefits to any monies owed or received for my benefit in the amount equal to any outstanding balance owed by me to the above named doctor or clinic.

In the event my insurance company or any other party obligated to make payments to me refuses to make payment upon demand by me or the above named doctor or clinic, I hereby assign and transfer to said doctor or clinic any and all causes of action I may have now or in the future against said party and do hereby authorize said doctor or clinic to prosecute said cause of action in my name or the name of said doctor or clinic and to compromise, settle or otherwise resolve such claim or cause of action.

I understand that I remain personally liable for all amounts due said doctor or clinic and that this Assignment and Authorization does not constitute consideration for said doctor or clinic to await payment and that the same may demand payment immediately upon rendering service and may charge interest at 15% per annum (compounded daily) on all balances after 30 days. If said doctor or clinic must take any collection action, I will be liable for all costs of collections actions, including court costs and reasonable attorney fees.

I authorize the above named doctor or clinic to release any records or information regarding my treatment to any insurance company, third party payor or attorney to facilitate collection of all benefits due me under this Assignment and Authorization and further authorize them to endorse on my behalf all checks and drafts issued to me, in my name or for my benefit.

This Assignment and Authorization shall be binding upon my legal heirs, personal representative(s), successors and assigns and any other person legally acting on my behalf.

Patient's Signature _____ SS#____-___-_____ Date:_____

Signature of Parent, Spouse or Guardian Authorizing Care_____
Date: _____

In Health,

Black Hills Health & Wellness Center