BLACK HILLS
HEALTH & WELLNESS CENTER

PERSONAL HISTORY

Date_____

Name (First, Middle, Last) _____ Preferred Name_____

DOB_____ Social Security No._____ Gender: M F

Billing Address_____ City_____ State____ Zip_____

Cell Phone _____ Carrier _____ Home Phone _____

Work Phone_____ Email Address_____

Check One: __ Married __ Single __ Widowed __ Divorced __ Separated No. of Children___

Business/ Employer_____ Type of Work_____

Business Address_____ City_____ State____ Zip_____

Name of Emergency Contact_____ Relationship_____ Phone_____

Address_____City_____State____ Zip_____

Referred to this Office By_____

INSURANCE INFORMATION

Date_____ Patients 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 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_____

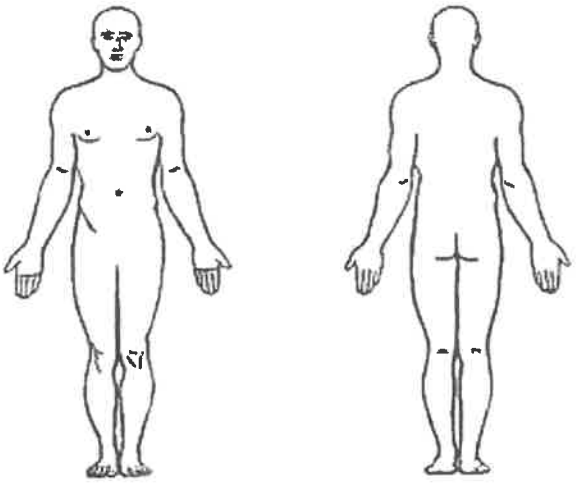
_____

TO THE NEW PATIENT

Outline of Procedure for New Patients

1. All new patients are requested to fill out a personal health/ history questionnaire
2. Your first consultation with a doctor to discuss your health problems
3. Diagnostic chiropractic, orthopedic and neurological examination procedures to determine if chiropractic care is appropriate for your condition
4. The Doctor will advise you as to need of additional procedures such as laboratory x-ray tests, if necessary.
5. If your case requires immediate attention, emergency aid will be administered
6. You will be advised as a time you can return for you "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. After you return and receive your "Report of Findings" your recommended treatment program will be explained to you. Consisting of an initial phase of relieve care followed by recommendation for corrective care.

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.



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 a 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 harmful chemicals (eg., pesticides, radioactivity, solvents) or health and/or life-threatening activities (eg., fireman, etc.)? _____

MEDICATION YOU CURRENTLY TAKE _____
FEMALES ONLY: When was your last period?_____ Are you pregnant? ___ Yes ___ No ___ Maybe
Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complains (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: #6 oz cups/day ____
- ☐ Soda w/ caffeine: # cans/day____
- ☐ Other sources
- ☐ Water: # glasses/day ____

BLACK HILLS HEALTH AND WELLNESS CENTER

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, diagnostic x-rays on myself (or the patient named below, for whom I am legally responsible) by the doctor or intern affiliated with the Black Hills Health and Wellness Center.

I understand that in the practice of medicine, and in the practice of chiropractic care that there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I expect the doctor to be able to exercise judgment during the course of the examination, for which the doctor feels at the time, (based on the facts then known), 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 Black Hills 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 conditions for which I seek treatment.

_____ _____

Patients Name (please print) Date

_____

Parent or Guardian's Signature

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.

_____ _____

Patient's Name (please print) Date

_____

Signature of Patient or Personal Representative

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
____Pre- certification/authorization
____Appointments
____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 revokes by a court of law

IRREVOCABLE ASSIGNMENT OF HEALTH CARE BENEFITS and AUTHORIZATION TO RELEASE HEALTH-CARE INFORMATION

To Whom it May Concern:

I hereby irrevocably assign, set over and grant a perfected security interest pursuant to the provisions of SDCL 57A-9 to Black Hills Health and Wellness Center (hereby referred to as BHHWC) in and to any and all health-care insurance receivables due to the undersigned as a result of health-care services provided me by the BHHWC 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 BHHWC.

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 BHHWC, I hereby assign and transfer to BHHWC any and all causes of action I may have now or in the future against said party and do hereby authorize BHHWC to prosecute said cause of action in my name or in the name of BHHWC to compromise, settle, or otherwise resolve such claim or cause of action.

I understand that I remain personally liable for all amounts due to BHHWC and that this Assignment and Authorization does not constituted consideration for BHHWC to await payment and that the same may demand payment immediately upon provided service. If BHHWC 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 BHHWC 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.

Patients Name (Print) Patients Signature

Guardian or Spouse's Signature Authorizing Care Date

Black Hills Health & Wellness Center, LLC
1220 Mt. Rushmore Rd, Ste 1
Rapid City, South Dakota 57701
PH: 605-341-7500

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Black Hills Health & Wellness Center, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date