PRAIRIE RIDGE
CHIROPRACTIC

DR. CHRIS WILLERS
DR. KODI LARSON
5629 S SOUTHEASTERN AVE
SIOUX FALLS, SD 57108
Ph: 605.274.7007 | F: 605.939.7113

Patient Information

Date_____ Sex: □ M □ F Age: _____
Patient Name_____
Address_____
City_____ State____ Zip Code_____

Birth Date_____ Height_____Weight_____

□Single □Married □Widowed □Separated □Divorced

Occupation_____
Employer_____

Whom may we thank for referring you?_____

Email Address_____

□ Opt out of marketing, newsletters, and promotional materials. Email address will only be used for contact regarding appointment scheduling and information related to current treatment.

Insurance

Subscriber's Name_____
Birth Date _____
Relationship to Patient_____

Insurance Company_____
Member ID#_____
Group#_____

Is patient covered by additional insurance? □ Y □ N
Subscriber's Name_____
Birth Date _____
Relationship to Patient_____

Insurance Company_____
Member ID#_____
Group#_____

_____
Responsible Party Signature

_____
Relationship Date

Phone Numbers

Home_____Work_____Cell_____
Best time and place to reach you:_____
_____

IN CASE OF EMERGENCY, CONTACT:
Name_____Relationship_____
Home Phone_____
Work Phone_____Ext_____

Accident Information

Is condition due to an accident? □ Y □ N Date_____
Type of accident □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp □ Other
Attorney Name/Phone # (if applicable)_____
_____

Health History

What treatment have you already received for your condition?
□ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None
□ Other_____

Name and address of other doctor(s) who have treated you for your current problem:_____

Date of Last: Physical Exam_____ Spinal X-Ray _____Blood Test_____
Spinal Exam_____ Chest X-Ray _____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Who is your primary care physician (First/Last Name)?_____
What is their address?_____
When was your last appointment with your primary doctor? _____
Was your last visit with your primary doctor related to your current problem? Yes No
May we contact your primary doctor regarding your condition? Yes No

Place a mark on "Yes" or "No" to indicate if you previously or currently have any of the following:

AIDS/HIV □ Y □ N
Alcoholism □ Y □ N
Anemia □ Y □ N
Anorexia □ Y □ N
Appendicitis □ Y □ N
Arthritis □ Y □ N
Asthma □ Y □ N
Bleeding Disorders
Breast Lump □ Y □ N
Bronchitis □ Y □ N
Bulimia □ Y □ N
Cancer □ Y □ N
Cataracts □ Y □ N
Chemical Dependency □ Y □ N
Chicken Pox □ Y □ N
Diabetes □ Y □ N
Emphysema □ Y □ N
Epilepsy □ Y □ N
Fractures □ Y □ N

Glaucoma □ Y □ N
Goiter □ Y □ N
Heart Disease □ Y □ N
Hepatitis □ Y □ N
Hernia □ Y □ N
Herniated Disc □ Y □ N
Herpes □ Y □ N
High Cholesterol □ Y □ N
Kidney Disease □ Y □ N
Liver Disease □ Y □ N
Measles □ Y □ N
Migraine Headaches □ Y □ N
Miscarriage □ Y □ N
Mononucleosis □ Y □ N
Multiple Sclerosis □ Y □ N

Mumps □ Y □ N
Osteoporosis □ Y □ N
Pacemaker □ Y □ N
Parkinson's Disease □ Y □ N
Pinched Nerve □ Y □N
Pneumonia □ Y □ N
Polio □ Y □ N
Prostate Problem □ Y □ N
Prosthesis □ Y □ N
Psychiatric Care □ Y □ N
Rheumatoid Arthritis □ Y □ N
Rheumatic Fever □ Y □ N
Scarlet Fever □ Y □ N
Stroke □ Y □ N
Thyroid Problems □ Y □ N

Tonsillitis □ Y □ N
TIA □ Y □ N
Tuberculosis □ Y □ N
Tumors Growths □ Y □ N
Typhoid Fever □ Y □ N
Ulcers □ Y □ N
Vaginal Infections □ Y □ N
Venereal Disease □ Y □ N
Whooping Cough □ Y □ N
Other_____
_____
_____
_____

Exercise	Work Activity	Habits	Yes	No	
□ Never	□ Sitting _____ hrs/day	□ Tobacco	□	□	⇒ Packs/Day_____
□ Occasionally	□ Standing____ hrs/day	□ Alcohol	□	□	⇒ Drinks/Week_____
□ Frequently	□ Light Labor	□ Coffee/Caffeine Drinks	□	□	⇒ Cups/Day_____
□ Daily	□ Heavy Labor	□ High Stress Level	□	□	⇒ Reason_____

Are you Pregnant? □ Yes □ No Date of last menstrual period_____ Due date_____
Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time. _____
initial

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Car Accidents		

Medications/Uses	Allergies	Vitamins/Herbs/Minerals

Family History

If there is a family history of any of the following health conditions, please check the appropriate box corresponding to your maternal (mother's) or paternal (father's) side.

	Mother	Father		Mother	Father
Respiratory Disease	□	□	Cancer	□	□
Hypertension	□	□	Heart Disease	□	□
Gastro-Intestinal Disease	□	□	Osteoporosis	□	□
Diabetes	□	□	Thyroid Disease	□	□
Skin Disease	□	□	Degenerative Disc Disease	□	□
Neurological Disease	□	□	Stroke	□	□
Arthritic Disease	□	□	Genital-Urinary Disease	□	□

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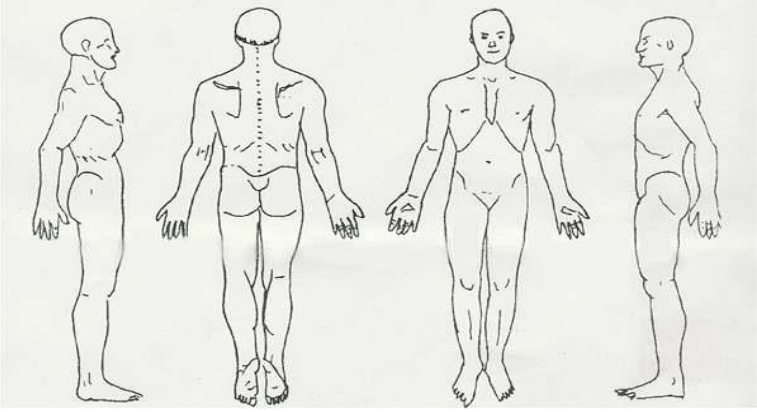
Please mark figures below in the location of your symptoms.



Have you seen any other physician of medical provider for your current complaint(s)? Yes No

Provider's name:_____
Location:_____

What was their diagnosis or impression of your condition?

_____

Primary Complaint

When did your symptoms begin? _____

Briefly describe how your symptoms began:_____

Location
- ☐ Neck
- ☐ Upper Back
- ☐ Low Back
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Headache
- ☐ Hamstring

Side
- ☐ Left
- ☐ Right
- ☐ Bilateral
- ☐ Center

Radiating to
- ☐ Shoulder
- ☐ Arm
- ☐ Hand/Fingers
- ☐ Buttock
- ☐ Hamstring
- ☐ Quadricep
- ☐ Lower Leg
- ☐ Foot/Toes

Type/Onset
- ☐ New Injury
- ☐ Reoccurrence of existing problem
- ☐ Unknown Cause
- ☐ Exacerbation of previous injury
- ☐ Chronic Pain
- ☐ Motor Vehicle Accident

Description
- ☐ Achy
- ☐ Stiffness
- ☐ Sharp
- ☐ Dull
- ☐ Tight
- ☐ Sore
- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Throbbing
- Shooting
- Stabbing

Frequency
- ☐ Occasional
- ☐ Intermittent
- ☐ Frequent
- ☐ Constant
- ☐ With Activity

Progression
- ☐ Getting Better
- ☐ Getting Worse
- ☐ Staying The Same

Aggravate
- ☐ Activity
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Running
- ☐ Bending
- ☐ Getting Up From Sitting
- ☐ Getting Up
- ☐ Lying Down
- ☐ Work Tasks
- ☐ Neck Movements
- ☐ Daily Activities

Alleviate
- ☐ Rest
- ☐ Ice
- ☐ Heat
- ☐ Exercise
- ☐ Medication
- ☐ Stretching
- ☐ Massage
- ☐ Topical Ointments
- ☐ Chiropractic Care

Pain Scale 0-10
Current_____
Average_____
Worst _____

Other Symptoms
- ☐ Lightheaded
- ☐ Dizzy
- ☐ Fevers
- ☐ Night Sweats
- ☐ Nausea
- ☐ Weakness
- ☐ Visual Abnormalities
- ☐ Bowel/Bladder Changes
- ☐ Weight Loss/Gain

Secondary Complaint

When did your symptoms begin? _____

Briefly describe how your symptoms began:_____

Location
- ☐ Neck
- ☐ Upper Back
- ☐ Low Back
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Headache
- ☐ Hamstring

Side
- ☐ Left
- ☐ Right
- ☐ Bilateral
- ☐ Center

Radiating to
- ☐ Shoulder
- ☐ Arm
- ☐ Hand/Fingers
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- ☐ Hamstring
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- ☐ Foot/Toes

Type/Onset
- ☐ New Injury
- ☐ Reoccurrence of existing problem
- ☐ Unknown Cause
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- ☐ Throbbing
- ☐ Shooting
- ☐ Stabbing

Frequency
- ☐ Occasional
- ☐ Intermittent
- ☐ Frequent
- ☐ Constant
- ☐ With Activity

Progression
- ☐ Getting Better
- ☐ Getting Worse
- ☐ Staying The Same

Aggravate
- ☐ Activity
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Running
- ☐ Bending
- ☐ Getting Up
- ☐ From Sitting
- ☐ Getting Up
- ☐ Lying Down
- ☐ Work Tasks
- ☐ Neck Movements
- ☐ Daily Activities

Alleviate
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- ☐ Ice
- ☐ Heat
- ☐ Exercise
- ☐ Medication
- ☐ Stretching
- ☐ Massage
- ☐ Topical Ointments
- ☐ Chiropractic Care

Pain Scale 0-10
Current_____
Average_____
Worst _____

Other Symptoms
- ☐ Lightheaded
- ☐ Dizzy
- ☐ Fevers
- ☐ Night Sweats
- ☐ Nausea
- ☐ Weakness
- ☐ Visual Abnormalities
- ☐ Bowel/Bladder Changes
- ☐ Weight Loss/Gain

For additional complaints use the back side of this page.

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Authorizations and Releases

Patient name (print) _____

Consent for Treatment And Legal Assignment of Benefits
I am aware of the nature and purpose of chiropractic care, the possible consequences and risks of chiropractic care, and the risks and consequences of receiving no such care. I acknowledge that no guarantees were made to me concerning results of treatment. Having this knowledge, I knowingly authorize the doctors of Prairie Ridge Chiropractic & Rehab, LLC to proceed with the treatment of chiropractic care. Also be advised that this office complies with the guidelines set forth in HIPPAA, which respects your right to privacy. If you are unaware of these rights, please ask for the "Notice of Privacy Practices" and we will provide that for you. In addition,

1. I agree to adhere to my treatment plan. By not doing so, I would release Prairie Ridge Chiropractic and Rehab, LLC from any consequences that could result from my own actions.
2. I certify that I provided my current insurance card and/ or all insurance information. I assign all insurance benefits payable to my treating physician at Prairie Ridge Chiropractic and Rehab, LLC. **I understand that I am financially responsible for all charges whether or not paid and/or covered by my insurance plan.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize this signature on all insurance submissions.
3. I agree to be personally responsible for my own property (including children).
4. I certify that the statements on these forms are accurate to the best of my knowledge and I have left nothing out.

Patient signature (guardian)_____ Date_____

Authorization To Release Medical Information
I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete. I also authorize the release of my medical information to and from other sources, including, health plans, health care providers, and/or sports personnel. I also understand that if the organization or individual(s) that I authorize to receive my personal health information is not a health plan or health care provider, the released information may be re-disclosed and may no longer be protected by federal privacy regulations.

Furthermore, I request and authorize treating physicians at Prairie Ridge Chiropractic and Rehab, LLC to release and/or receive specified information from treatments at the given facility. Information released may include, but is not limited to: Medical Records, Medical Statements/Bills, Doctor Soap Notes, X-Rays, X-Ray Reports, Laboratory Reports, Operative Reports, and Pathology Reports.

I understand that I may revoke this authorization at any time by notifying Prairie Ridge Chiropractic and Rehab,LLC in writing. However, I fully understand that the revocation will not have any effect on any actions taken before the revocation.

Patient signature (guardian)_____ Date_____

Request For Payment Of Benefits To Provider Of Care
I hereby authorize the_____ insurance company/ insurance administrator to pay by check, and for it to be mailed directly to Prairie Ridge Chiropractic and Rehab, LLC, 3700 S Kiwanis Ave, Suite 3, Sioux Falls, SD 57105. The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/ sign my name on any and all drafts for payment of my bill.
Patient Signature (guardian)_____ Date_____

Parent Consent To Treat A Minor
I hereby authorize treating physicians at Prairie Ridge Chiropractic and Rehab, LLC to perform all necessary treatmetn modalities, diagnostic tests, including but not limited to radiographs, and to administer treatment as he/ she deems necessary to my child.
Guardian signature_____ Date_____