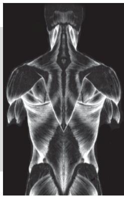

Active Spine & Rehabilitation

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Sioux Falls, SD 57108
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Lance Fredrickson, DC | J.D. Dorman, DC | Wayne Huber, DC CCSP | Chris Willers, DC

Please take a moment to introduce yourself. All information will remain in your personal file and will be kept strictly confidential.

PERSONAL INFORMATION:

First Name: ___________________MI:____ Last: ____________________________ Date of Birth: ____/____/_____ Age: _____

Mailing Address: _________________________________ City: ______________________ State: _______ Zip Code: ___________

Home Phone: ________________________ Work Phone: _______________________ Cell Phone: ________________________

SSN: ________-______-________ Marital Status: M S E D W Spouse/Significant Other: _______________________________

Occupation: ____________________________________ Employer: ________________________________ Hrs/Week: ________

Primary Work Activity: ____________________________ Children Name(s)/Ages: _______________________________________

Full Time Student ☐ Yes ☐ No Part-Time Student ☐ Yes ☐ No Name of School: ____________________________

Emergency Contact: ____________________________ Relationship: ___________________ Phone Number: ________________

Payment Method: Insurance/Copay Cash Credit Card Check Person Responsible for Payment: ___________________

Who may we thank for referring you to us? Yellow Pages Website Advertisement Referral: ________________________

Email Address: _____________________________@______________________________ For News and Discounts

LIFESTYLE

Current Weight: ____________ Have you recently lost or gained weight? ☐ Yes ☐ No Current Height: ____________

Mental Work: ☐ Heavy ☐ Moderate ☐ Light ☐ None Physical Work: ☐ Heavy ☐ Moderate ☐ Light ☐ None

Exercise: ☐ Heavy ☐ Moderate ☐ Light ☐ None Type:___________________ Diet: ☐ Excellent ☐ Fair ☐ Poor

What type(s) of sports/activities do you participate in/enjoy? ____

Smoking: ☐ None ☐ Current ☐ Previous Packs/Day: _______ # of Years Smoked: _______ # of Years Quit: _______

Alcohol: ☐ None ☐ Heavy ☐ Moderate ☐ Social Drinks/Wk: _______ Caffeine/Day: ______________________

Females: Could you be pregnant? ☐ Yes ☐ No If Yes, How Far Along? ___________ Due Date: ______________

List any health goals that you may have: ____

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 Active Spine & Rehabilitation 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 Active Spine & Rehabilitation 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 Active Spine & Rehabilitation. **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: _________________________________ Parent/Guardian Signature (If Minor): ________________________

Today’s Date: ________________________ Signature of Treating Doctor: ____ ⇨

Review of Systems – Please check the symptoms you have now or have had in the past.

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐

SKIN	NOW	PAST
Sores	☐	☐
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Weakness	☐	☐

HEAD	NOW	PAST
Headaches	☐	☐
Trauma	☐	☐
Contacts	☐	☐
Glasses	☐	☐
Cataracts	☐	☐
Last Eye Exam	______ MM	______ YY

EARS	NOW	PAST
Difficulty Hearing	☐	☐
Ringing	☐	☐
Earache	☐	☐

NOSE	NOW	PAST
Decreased Smell	☐	☐
Pain	☐	☐
Deviated Septum	☐	☐
Sinus Congestion	☐	☐

MOUTH	NOW	PAST
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Loss of Taste	☐	☐

THROAT	NOW	PAST
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐

LUNGS	NOW	PAST
Chronic Phlegm	☐	☐
Cough Blood	☐	☐
Pain With Breathing	☐	☐
Short Of Breath	☐	☐
Wheezing	☐	☐
Asthma	☐	☐

HEART	NOW	PAST
Murmur	☐	☐
Palpitations	☐	☐
Rapid Beat	☐	☐
Swollen Arms/Legs	☐	☐
Temp. Difference Between Arms/Legs	☐	☐
Chest Pain	☐	☐
Blood Clots	☐	☐

BLOOD	NOW	PAST
Anemic	☐	☐
Low Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐

GASTROINTESTINAL	NOW	PAST
Chronic Abdominal Pain	☐	☐
Nausea	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Bloody Stool	☐	☐

GENITOURINARY	NOW	PAST
Blood in Urine	☐	☐
Incontinence	☐	☐
Frequent Voiding	☐	☐
Kidney Stones	☐	☐
Burning/Painful Urination	☐	☐
Discharge	☐	☐
Spotting	☐	☐
Menstrual Cramps	☐	☐
Itching	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐
Changes in Menstrual Flow	☐	☐

Contraception Type___________________

No. of Pregnancies________

No. of Births________

NEUROLOGICAL	NOW	PAST
Seizure	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
In coordination	☐	☐
Difficult Speech	☐	☐
Facial Control Loss	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Numbness	☐	☐
Tingling	☐	☐

ENDOCRINE	NOW	PAST
Weight Loss	☐	☐
Weight Gain	☐	☐
Heat Intolerance	☐	☐
Cold Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

PSYCHIATRIC	NOW	PAST
Extreme Worry	☐	☐
Hyperventilation	☐	☐
Depression	☐	☐
Troubled Sleeping	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Dependency	☐	☐
Suicidal Thoughts	☐	☐

PAST MEDICAL HISTORY – Including Family

	Yourself	Family Member
Leukemia	☐	☐
Paralysis	☐	☐
Kidney Infections	☐	☐
Rheumatic Fever	☐	☐
Diabetes	☐	☐
Mental Illness	☐	☐
Gallstones	☐	☐
Thyroid Problems	☐	☐
Ulcers	☐	☐
Heart Attack	☐	☐
Cancer	☐	☐
High BP	☐	☐
Stroke	☐	☐
Hepatitis	☐	☐
Epilepsy	☐	☐

List any Allergies: ________________________

Medications: **Reason for Taking:**

____

____

Surgeries: **Type/Date:**

____

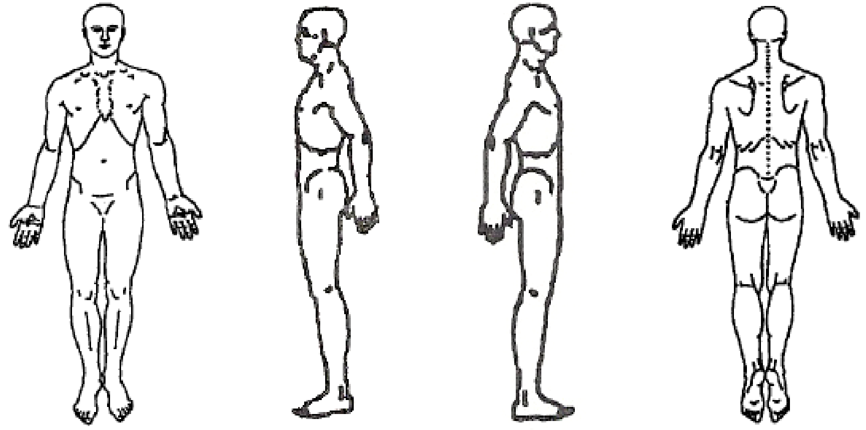
____

Signature: ____ **Patient:** ____

By my signature I verify that the information provided is valid and I have left nothing out.

Circle the are of complaint or pain using the diagrams on the right.

Use these abbreviations for descriptors:
A – Ache
BP – Burning Pain
C – Cramp
D – Dull Pain
N – Numbness
PNS – Pins and Needles
S – Stiffness
SSP – Sharp/Stabbing Pain
T – Throbbing
TSP – Traveling/Shooting Pain



Date of Onset: ______________ ☐ Unknown Initial Onset: ☐ Sudden ☐ Gradual Frequency: ☐ Constant ☐ Intermittent

Condition Is: ☐ Improving ☐ Worsening ☐ Not Changing Condition is interfering with: ☐ Work ☐ Sleep ☐ Daily Routine

Rate your Pain on a scale from 1-10 (1 – Minimal, 10 – Excruciating): At Best _____ At Worst _____ Average _____ Current _____

Was there an injury? ☐ No injury ☐ Sports ☐ Work ☐ Motor Vehicle ☐ Other ____________________________________

Description of Injury: ___________________________________ ☐ Unknown (If Motor Vehicle / Work Related, Ask for Proper Forms)

Do you have any numbness/tingling/symptoms that radiate to other areas? ☐ Yes ☐ No If Yes, Where? ______________________

Do you have pain that awakens you at night? ☐ Yes ☐ No

Do you have temperature discrepancies between either hands or feet? ☐ Yes ☐ No If Yes, Explain: _______________________

Please circle as many of the following as needed.

What makes your pain **worse?** Sitting Standing Walking Coughing Straining Bending Extending Lying down Getting up

What makes your pain **better?** Sitting Standing Resting Lying Down Stretching Ice Medication Nothing

Have you experienced any…			**If Yes, Explain:**
bowel or bladder changes?	☐ Yes	☐ No	_____________________________________
difficulty breathing?	☐ Yes	☐ No	_____________________________________
chest pains?	☐ Yes	☐ No	_____________________________________
lightheaded or dizziness?	☐ Yes	☐ No	_____________________________________
headaches?	☐ Yes	☐ No	_____________________________________
fevers?	☐ Yes	☐ No	_____________________________________
night sweats?	☐ Yes	☐ No	_____________________________________

Have you had similar concerns in this area that required treatment in the past? ☐ Yes ☐ No If Yes, Explain:

____

Have you received chiropractic care before? ☐ Yes ☐ No If yes, when and from whom? _________________________________

What have you done for the pain? ☐ Rest (time off work) ☐ Ice ☐ Heat ☐ Massage ☐ Other ___________________

Who have you seen for this complaint? ☐ Family Doctor ☐ Chiropractor ☐ Orthopedist ☐ Physical Therapist ☐ Other

Please name health care professionals marked above and their practice location: ____

What were the results of the treatment? ____

In the past, have you had…?

Evaluations: ☐ MRI or CT scans ☐ X-rays If yes, how long ago and what region? _____________________________

Treatment: ☐ Epidural Steroid ☐ Spine Surgery If yes, how long ago and what region? _____________________________