**Plains Edge Chiropractic, Inc. Aberdeen, SD (605)262-0303**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work/Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height\_\_\_\_’\_\_\_\_” Weight\_\_\_\_\_\_\_\_lbs. Marital Status\_\_\_\_\_\_\_\_\_\_Gender: 🗆 M 🗆 F**

**Your Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Your Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How’d you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_**

1. What is your main complaint today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Explain how it occurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. When did it occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Has your condition gotten worse since it started? 🗆Yes 🗆No

4. On the figure to the right, please mark all areas of symptoms--------🡪

Right

Left

Front

Back

R

R

L

L

5. What describes the nature of your symptoms?

 (Check all that apply)

🗆 Sharp 🗆Dull ache 🗆 Numbness

🗆 Shooting 🗆Burning 🗆 Tingling

🗆 Tightness 🗆Pins/Needles 🗆 Throbbing

6. How would you rate your symptoms at their: (please circle)

Best: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

General: 1 2 3 4 5 6 7 8 9 10

Worst: 1 2 3 4 5 6 7 8 9 10

7. Do your symptoms radiate or shoot to other areas? 🗆Yes 🗆No

A. If yes, to where do they radiate?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. What activities make your symptoms worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. What activities make your symptoms better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Who have you seen for your symptoms?

🗆No one 🗆Medical Doctor 🗆Other Chiropractor 🗆Physical Therapist 🗆Other

A. When, where, and what kind of treatment was performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **REVIEW OF SYSTEMS - do you currently have, or have you ever had issues with any of the following:**

 **YES NO YES NO**

**Allergies Cardiovascular/Vascular**

Seasonal **⃝** **⃝** Heart/Vascular Disease **⃝** **⃝**

Environmental **⃝** **⃝** High Blood Pressure **⃝** **⃝**

**Eyes Respiratory**

Cataracts **⃝** **⃝** Asthma **⃝** **⃝**

Glaucoma **⃝** **⃝** COPD **⃝** **⃝**

Retinal Detachment **⃝** **⃝** Emphysema

Lasik **⃝** **⃝ Gastrointestinal**

Blindness **⃝** **⃝** Esophageal Issues **⃝** **⃝**

Macular Degeneration **⃝** **⃝** Excessive Gas **⃝** **⃝**

**Ears/Nose/Throat** Constipation **⃝ ⃝**

Chronic Cough **⃝** **⃝** Loose Stool **⃝ ⃝**

Congestion **⃝** **⃝ Genitourinary**

Hearing Loss **⃝** **⃝** Kidney/Bladder **⃝ ⃝**

Tinnitus/Ringing Ears **⃝** **⃝** **Lymphatic/Hematologic**

**Skin** Bleeding Problems **⃝** **⃝**

Texture Changes **⃝** **⃝ Psychiatric**

Color Changes **⃝** **⃝** Depression **⃝** **⃝**

Melanoma **⃝** **⃝** **Endocrine**

**Arthritis** Diabetes **⃝ ⃝**

Psoriatic **⃝** **⃝** Thyroid/Gland Issues **⃝ ⃝**

Rheumatoid **⃝** **⃝**

Osteroarthritis **⃝** **⃝** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate if an immediate family member has had any of the following:

○ Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ High blood pressure ○ Epilepsy

○ Anemia ○ Multiple Sclerosis ○ Thyroid Disease ○ Lupus ○ Stroke ○ Kidney Disease

○ Osteoporosis ○ High Cholesterol ○ Glaucoma ○ Asthma ○ Arteriosclerosis ○ Other

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all the surgical procedures you have had and times you have been hospitalized:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain how your current condition has affected your work, recreational activities, or home life:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dr. Andrew L. Johnson

12 6th Ave SW

Aberdeen, SD 57401

Phone (605)262-0303 Fax (605)262-0529

**Chiropractic Informed Consent for Diagnosis and Treatment**

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment carries with it some risks. The serious risks associated with the chiropractic adjustment are extremely rare. Following are the known risks:

**Temporary soreness or increased symptoms or pain**. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

**Dizziness, nausea, flushing**. These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

**Fractures**. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture.

**Disc herniation or prolapse**. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

**Stroke**. A certain extremely rare type of stroke has been associated with chiropractic care. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. *I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction* ***prior to my signing this informed consent document***. I have discussed or been given the opportunity to discuss any questions or concerns with. I have made my decision voluntarily and freely.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, D.C. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Chiropractor Date

Dr. Andrew L. Johnson

12 6th Ave SW

Aberdeen, SD 57401

Phone (605)262-0303 Fax (605)262-0529

**Acknowledgement of receipt of HIPAA Privacy Notice**

I have been presented with a copy of Plains Edge Chiropractic, Inc. Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information (write below):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

**Signature of patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If not signed by patient, please indicate relationship to patient (e.g., spouse)

**Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witnessed by (Dr. Andrew Johnson) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I give my permission for medical records, medical information, financial information, and appointments to be shared with my immediate family, guardian, or employer. If you would like for the above information to be shared with someone, please list their name below and sign your initials. If not, you may leave this blank.**

 **Initial of Pt\_\_\_\_\_\_\_\_\_\_**

By signing below the patient acknowledges they are responsible for all charges due at Plains Edge Chiropractic, Inc.. These charges include, but may not be limited to, ***co-pays, co-insurance, charges applied to deductible, or non-covered services.*** Plains Edge Chiropractic, Inc. will submit to your insurance on your behalf. Plains Edge Chiropractic, Inc. does not verify chiropractic coverage with the insurance carrier before treatment. It is the patients’ responsibility to know what their insurance does and does not cover. Also, if payment for services is not received within 6 months, your balance will be sent to the creditor, which will have a detrimental effect on your credit rating.

Plains Edge Chiropractic, Inc. is non-participating with Medicare, and does not accept assignment. Plains Edge Chiropractic, Inc. will submit to Medicare on your behalf, and Medicare will reimburse the patient directly for all covered services. Again, it is the patients’ responsibility to know what is covered and not covered by their insurance.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_