Pascoe Chiropractic
2101 West 41st Street, #4
Sioux Falls SD 57105
(605) 271-4109

Name:	Date: / /

Patient Introduction Form

SS#_____ Date of Birth_____ Height____'____" Weight_____lbs. Gender: □ M □ F

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone _____

Marital Status_____ Number of Children _____ Employer _____ Occupation _____

Would you like Email or TEXT Reminders? If Yes, who is your cell phone Provider _____

Email Address: _____ Who Referred You? _____

Primary care physician name: _____

Have you had X-Rays? □ Yes □ No What body part(s)? _____ Where were they taken? _____

Women only: Are you pregnant? □ Yes □ No How far along are you? _____

Insurance Information (If Applicable) □ Cash Payment □ Insurance □ Auto Accident □ Job Related

Insurance Company _____ Group/Policy #_____
Provider Contact Phone #_____ Primary Policy Holder_____

Cardholder's Birthdate _____/_____/_____ SS#_____ Cardholder's Employer_____

Initial History

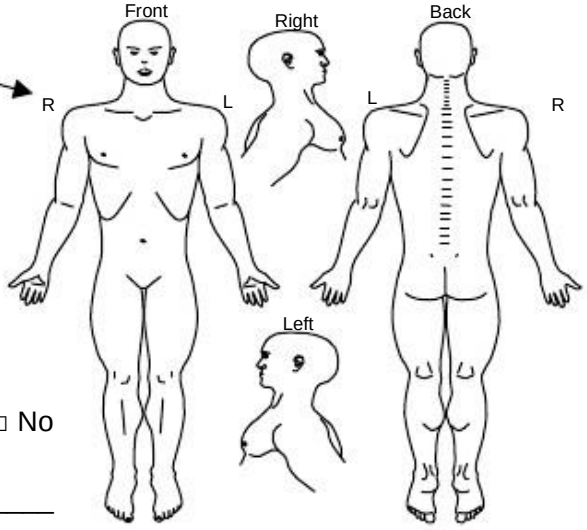
☺ Please answer every question so we can provide you with the best possible service. If you have any questions or need help filling out this form, please ask one of the staff. We will be happy to assist you.

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?



5. Describe what it feels like: □ sharp □ stabbing □ dull □ ache
□ tightness □ pulling □ burning □ numbness □ tingling
□ pins & needles □ throbbing □ other:_____

6. On the following scale please circle the intensity/severity

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

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

a) If yes, where to? _____

8. Are your symptoms constant?---------- □ Yes □ No

a) If not, when are they and/or how long do they last?_____

9. List anything (activities, medication, etc.) that makes your condition better or worse:_____

_____

10. Have you previously received chiropractic care?---------- □ Yes □ No

a) If yes, from whom? _____

11. Have you been treated for this complaint before?---------- □ Yes □ No

a) If yes, by whom?_____ b) When was your treatment?_____

12. Has your complaint caused a change or relationship with any other parts of your body? (e.g., hearing, vision, eating, sleeping, digestion, breathing, balance, strength, or other) ---------- □ Yes □ No

13. Is your current complaint related to an accident?---------- □ Yes □ No

a) If yes, was it from: □ Auto □ Work Related □ Other (describe)_____

b) If work related, was your employer notified?---------- □ Yes □ No

c) Have you missed any work due to your accident?---------- □ Yes □ No

14. Have you ever had any trauma or accidents other than normal bumps and bruises?---------- □ Yes □ No

a) If yes, what? _____

15. Have you ever had any illnesses other than colds, flus, and normal childhood illnesses?---------- □ Yes □ No

a) If yes, what? _____

16. Have you ever had surgery (prosthetic hips, knees, pacemaker or any other devices)?---------- □ Yes □ No

a) If yes, what? _____

17. Are you taking any medication?---------- □ Yes □ No

a) If yes, please list the medication(s) and what it is for:

_____

18. What type of job do you do (lifting, sitting, standing, driving, walking, etc.)? _____

19. What types of activities do you participate in?_____

20. Have any of your blood relatives had any of the following? (check each that apply)

□ Arthritis □ Heart disease □ High blood pressure □ Kidney disease □ Tuberculosis □ Allergies

□ Thyroid disorders □ Cancer (type): _____ □ Other: _____

Please mark any of the following you have had difficulty with:

- □ Numbness in arms or hands
- □ Pins & Needles in arms or hands
- □ Pain in arms or hands
- □ Pain in legs or feet
- □ Numbness in legs or feet
- □ Pins & Needles in legs or feet
- □ Headaches
- □ Disc problems
- □ Jaw problems
- □ Joint swelling
- □ Painful joints
- □ Arthritis
- □ Chest pains
- □ Heart problems
- □ High blood pressure
- □ Low blood pressure
- □ Sinus problems
- □ Asthma
- □ Stomach problems
- □ Kidney problems
- □ Bladder problems
- □ Frequent urination
- □ Diabetes
- □ Gallbladder problems
- □ Cancer
- □ Fever
- □ Sleeping problems
- □ Tension
- □ Lights bother eyes
- □ Loss of balance
- □ Prostate problems
- □ Menstrual cramps
- □ Swollen ankles
- □ Unexplained weight loss
- □ Excessive fatigue
- □ Smoking
- □ Frequent illnesses
- □ Night pain
- □ Thyroid problems
- □ Anemia
- □ Hernia
- □ Weakness
- □ AIDS/HIV
- □ Blurred or double vision
- □ Complete or partial loss of vision in one or both eyes
- □ Ringing, buzzing or any noise in your ear(s)
- □ Recent hearing loss in one or both ears
- □ Slurred speech or other speech problems
- □ Difficulty swallowing
- □ Dizziness
- □ Temporary disorientation or confusion
- □ Loss of consciousness or momentary blackouts
- □ Numbness or loss of feeling in the face, fingers, hand, arms, legs, or other part of your body
- □ Weakness, clumsiness, or loss of strength in your face, fingers, hands, arms, or legs
- □ Sudden collapse without loss of consciousness
- □ Sudden severe pain in the side of your head and/or neck, which is different from pain you have had before
- □ Loss of taste or smell
- □ Stroke
- □ Other (describe):_____
  _____
  _____

21. In what position(s) do you sleep? □ Back □ Stomach □ Side □ Other: _____

22. Do you "pop" your own joints or do they ever "pop" on their own?---------- □ Yes □ No

Consent to Treatment

I _____(PRINT) authorize Dr. Angela M. Pascoe to perform chiropractic adjustments, treatments and procedures. I further consent to examinations, consulting services, and diagnostic procedures rendered in conjunction with the adjustments, treatments, and procedures.

Release of Information

Dr. Angela M.Pascoe may disclose information from the patient's records to doctors, hospitals, or others for Continuous care and to any third party who requires that information in order to fulfill an obligation benefiting the patient.

Responsibility for Payment

I acknowledge my responsibility to and agree to pay in full for the professional services rendered. I understand that if the doctor may bill my health insurer for the services, such billing does not relieve me of my responsibility to pay for the services. I also understand a charge will be made for broken appointments unless 24 hours notice is given. I agree to pay for any costs incurred as a result of sending my bill to a collection agency or any other legal action as Well as 1.5% interest per month on any money owed for service rendered.

Informed Consent of Risks

I understand that chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur ranging from a minor aggravation of current condition to serious conditions such as cerebral vascular accidents. I also understand that the doctor is not liable for any problems that might arise if I decide not to follow the treatment in which he prescribes. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to chiropractic care, including but not limited to sprain and strain, fractures, dislocations, and general aggravations of inflammatory conditions. I understand that I will have an opportunity to discuss with the doctor and/or intern and/or other office personnel the nature and purpose of the chiropractic procedures I will receive.
I understand that the doctor and/or intern will perform an examination in order to minimize any risk of care,

however, I do not expect the doctor and/or intern to be able to anticipate and explain all risks and complications. I therefore wish to rely on the doctor and/or intern to exercise judgment during the course of the procedure which the doctor and/or intern feels at the time, based upon the facts as then known, is in my best interest.

Medicare Patients Authorization and Assignment of Benefits

I authorize payment of government benefits to Pascoe Chiropractic who accepts assignment for services covered by Medicare. I also understand it is my responsibility to pay for all other services which Medicare does not cover.

CVA Signs

If during your visit you suffer from any of the following please notify the doctor or staff immediately:

1. Sudden severe pain in the side of your head and/or neck
2. Vision problems
3. Numbness, loss of feeling, or abnormal feeling
4. Weakness, clumsiness, or loss of strength
5. Dizziness
6. Hearing problems
7. Disorientation or confusion
8. Speech problems
9. Loss of consciousness or momentary blackouts

I have read, or have had read to me, the above consent and reviewed the information herein and represent that the same is true, correct and complete. I understand that the doctor is relying upon the information in rendering treatment. By signing below, I agree to the procedures. I intend this consent form to cover the entire course of care for my present condition(s) and for any future condition(s) for which I seek care.

Signature: _____ Date: _____

Emergency Contact: _____ Phone: _____
Relationship to Patient: _____

---------- End of questionnaire. Please DO NOT write below this line ----------

Doctor's comments regarding question:_____

_____

_____

_____

_____

_____

_____

_____

Initial Exam

BP_____/_____ HR_____bpm RPM_____

Vertebrobasilar Circulation	(-)	Results					Indications	Comments
VBA Maneuver		R rot	Dizziness	Nausea	Vision problems	Nystagmus	Ipsilateral VBA or carotid insufficiency	
		L rot	Dizziness	Nausea	Vision problems	Nystagmus		