

**Welcome to  
Alternative Health Care Center  
of the Black Hills**



Name: \_\_\_\_\_ Prefer to be Called: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Mobile: ( ) \_\_\_\_\_

E-mail (for newsletters): \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Names and Ages of Children: \_\_\_\_\_

Patient's Employer/Business: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_

Previous Chiropractic Care?  Yes  No Date last seen: \_\_\_\_\_

Do you have insurance?  Yes  No Subscriber \_\_\_\_\_ D.O.B.: \_\_\_\_\_ S.S.N.: \_\_\_\_\_

Company: \_\_\_\_\_ ID Number: \_\_\_\_\_ Policy Group Number: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

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

**REASON FOR PURSUING CHIROPRACTIC CARE (please check):**

**Your Present Complaint:** \_\_\_\_\_

- I'm continuing ongoing care from another chiropractor.
- I'm interested in wellness and natural health care.
- I'm concerned about my health and I'm looking for answers.
- I want to improve my immune function.
- I have no idea why I'm here. Please take the time to explain to me what you do.

**In order for us to better understand your current level of health, please check any of the following body signals which you have or have had previously:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Headache/Migraine   | <input type="checkbox"/> Scoliosis   |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Heart Conditions    | <input type="checkbox"/> Sinus/Allergy Problems                                      |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Ear Infections     | <input type="checkbox"/> Kidney Problems     | <b>Are you Pregnant?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Menopausal Symptoms |  |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Multiple Sclerosis  |  |

**Please check any conditions common to family members:**

- |                                     |  |                                    |                                 |
|-------------------------------------|--|------------------------------------|---------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke    |                                 |

**Please list any prescription and over the counter medications you are now taking:**

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

**Known Allergies:** \_\_\_\_\_

**The following areas of stress can cause mis-aligned vertebrae (subluxation).  
Which of these stresses do you recognize?**

**PHYSICAL STRESS:**

**COMMENTS:**

Birthing Trauma (as a mother or child)	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Slips/Falls	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Auto Accidents	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Sports Injuries	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Poor Posture	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Sitting on a Wallet for Years	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Poor Sleeping Habits (on stomach or bad bed)	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Long Hours Sitting/Standing/Driving	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Carrying a Heavy Purse/Bookbag/Child	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Repetitive Lifting/Bending	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Broken Bone(s)	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Surgery	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current

**CHEMICAL STRESS:**

Poor Diet (Fast Food, Junk Food, Sodas)	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Excessive Caffeine Intake	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Artificial Sweeteners	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Cigarette Smoking/Second Hand Smoke	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Environmental Pollutants	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Excessive Alcohol Intake	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Over the Counter Drugs (Aspirin, Advil, etc.)	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Prescription Drugs	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current

**EMOTIONAL STRESS:**

Relationships	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Career/Money	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Children	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Illness or Loss of Loved One	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Fast-Paced Life	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Non-expressive w/Feelings	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Quick Tempered	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current
Verbal Abuse	<input type="checkbox"/> N/A	<input type="checkbox"/> Past	<input type="checkbox"/> Current

Which do you feel are your primary stresses? \_\_\_\_\_

It is important we have the same health objectives concerning chiropractic care. Our practice objective is to eliminate a major interference to the expression of the body's internal wisdom. We believe that the greatest Doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies the information given in this form is complete and correct and you accept, if eligible, chiropractic care on this basis.

Signature \_\_\_\_\_

Date: \_\_\_\_\_