Dr. Jerrid Goebel **Dr. Al Gunderson**

1010 Ballpark Rd. Ste.2 Sturgis, SD 57785
Phone: 605-561-0161 **Email:** office@keycitychiro.com

Date: _____ Social Security # _____

Name: _____ Birth Date: _____ Age: _____

Mailing Address _____ Physical Address _____

City _____ State ___ Zip_____ City _____ State ___ Zip_____

Email Address _____ Home Phone: _____

Cell Phone: _____

Gender: M / F Marital Status: M / S / D / W

Occupation: _____ Employer: _____

Spouse or Parent Name (if under 18): _____ Number Of Children: _____

Referred By: Google __ Social Media __ Other __ Family/Friend/Doctor _____

Circle Appropriate Coverage: Self Pay Insurance Medicare Medicaid/Title19
Automobile Accident Worker's Comp Personal Injury

Insured Name (If not patient) _____ Insured Birth Date: _____

Do You Have a Pacemaker: Y N

REASON FOR TODAY'S VISIT:_____

Is this condition: New Injury Old Injury Chronic Pain Wellness Visit

When Did This Condition/Accident Occur: ___/___/___ Where: _____

Circle Type of Pain/Discomfort: Dull Sharp Achy Throbbing Shooting
Burning Stabbing Numbness Other_____

Rate Your Pain/Discomfort: 1 2 3 4 5 6 7 8 9 10

Does Pain Radiate/Travel in to Other Parts of Body: Y N Where:_____

Does Your Condition Interfere With: Sleep Daily Activity Work

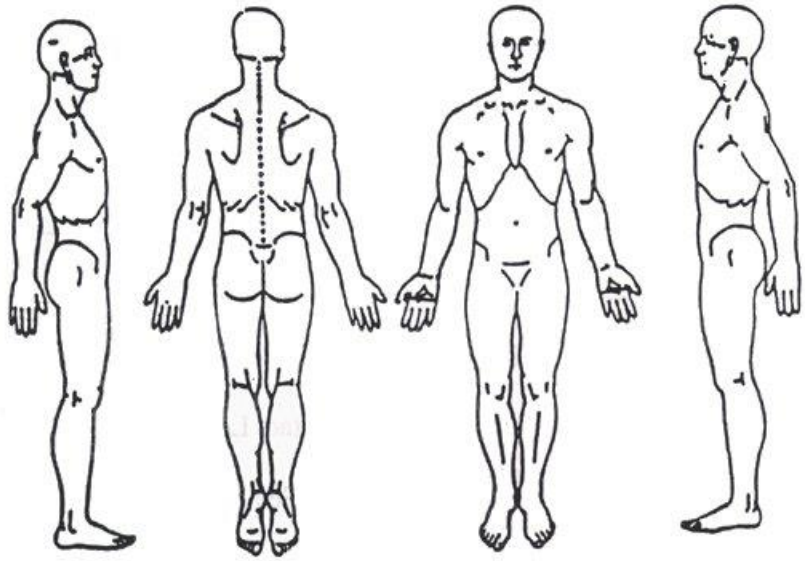
Recent Health Issues/Complications: _____

Recent Surgeries/Dates: _____

Medications: _____

Allergies: _____

Circle Areas of Symptoms:



Height: _____
Weight: _____

Currently Pregnant Y___ N___
Due Date_____

Do any of the following concern you:

□ Ear Ringing
□ Earache
□ Stiff Neck
□ Sinus Congestion
□ Cancer
□ Allergies
□ Difficulty Breathing
□ Asthma
□ Constipation
□ Diarrhea
□ Heartburn/ Indigestion
□ Muscle Twitching
□ Joint Stiffness
□ Joint Pain
□ Thyroid Condition
□ Tension Headache
□ Migraine
□ Heart Palpitation
□ Neck Soreness
□Hypertension
□ Depression
□ Anemia
□ Diabetes
□ Muscle Pain
□ Muscle Weakness
□ Muscle Cramps
□ Weak Grip
□ Facial Paralysis
□ Difficulty with Speech
□ Urinary Trouble
□ Angina
□ Heart Murmur
□ Breast Changes
□ Stroke
□ Hair Changes
□ Seizures
□ Vertigo
□ Dizziness
□ Hand Trembling
□ Loss of Sensation
□ Uncoordinated
□ Abdominal Pain
□ Menstrual Cramps
□ Bladder Trouble
□ Numbness
□ Tingling
□ Heat Intolerance
□ Cold Intolerance
□ Acupuncture

Is there anything else you would like the Dr. to know or would like more information on?

Please READ AND INITIAL the following:

Acknowledgement of Receipt of Notice of Privacy Practices: I have read/acknowledged the Notice of Privacy Practices for Protected Health Information. Notice of Privacy Practices is available at the front desk upon request.

Initials _____

Payment Policy: I acknowledge I am financially responsible for all charges incurred at Key City Chiropractic & Acupuncture PC. It is the policy of this office that payment be made at the time of service for all services rendered. A copy of this policy is available at the front desk upon request.

Initials _____

Insurance Assignment: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____

Signature of Patient or Parent/Guardian _____ Date _____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including chiropractic adjustments, examinations, various modes of physiotherapy, acupuncture, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Key City Chiropractic & Acupuncture PC and /or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers, including those working at the clinic or office.

I will discuss with the Key City Chiropractic & Acupuncture, PC provider and/or with other office or clinic personnel the nature and purpose of the procedures, if I choose to do so.

I understand, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the Key City Chiropractic & Acupuncture, PC provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I further understand that treatment is designed to improve health. I can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but not limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; steroid injections; bracing; and surgery. I understand I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I will ask the doctor questions about its consent if I have any, and by signing below I agree to the above-named procedures. I intent this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____