



Dr. Jerrid Goebel
Chiropractor/Licensed Acupuncturist

Dr. Stuart Johnson
Chiropractor

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Patient's Name _____ Nickname _____ Date ____/____/____

Address _____ City _____ State _____ Zip _____

Soc. Sec. # _____ Sex: M ____ F ____

Marital Status: M ____ S ____ D ____ W ____ Spouse's or Parent's Name _____

Date of Birth ____/____/____ Age _____

Home Phone _____ Work _____ Cell _____ Email _____

Referred By: Yellow Pages _____ Doctor _____ Other _____
Newspaper _____ Friend _____
Radio _____ Family _____

Occupation _____ Employer _____

Insurance Company _____
(We will photocopy insurance card)

What is the main reason for visiting our office today? _____

How long have you had this condition? _____ Date of Incident ____/____/____

Work Related? _____ Auto Accident? _____ Other Type of Accident? _____

Have you had this or similar conditions in the past? _____
(If so, please explain)

Is this condition interfering with: Work ____ Sleep ____ Daily Routine ____ Other _____

Other doctors or therapists who have treated THIS Condition: _____

Has this condition: Improved _____ Unchanged _____ Worsened _____

Family Physician: Name _____ Date of Last Physical: ____/____/____

Do you have a Pacemaker? _____ Medications? _____

Recent Surgeries/Dates: _____

