CONFIDENTIAL HEALTH INFORMATION

Patient Name_____ Nickname _____ Age ____ Gender ____

Guardian (if minor) _____ SS # _____

Address _____ City _____ State ____ Zip _____

Phone (cell) _____ Email _____Birthdate _____

Race ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Decline to answer

Occupation _____ Employer _____ Work # _____

Emergency Contact / Relation _____ Cell # _____

Primary Care Provider _____ Contact # _____

Whom may we thank for referring you? _____

Prior Chiropractic Whom? _____ When? _____ Why? _____

Please describe your Primary Complaint below. Use the Secondary and Additional Complaint Boxes if they apply.

PRIMARY COMPLAINT _____

Date of Onset & Cause of Complaint _____

Prior Intervention ☐Prescription drugs ☐Non-prescription drugs ☐ Physical therapy ☐ Surgery ☐ Acupuncture ☐ Chiropractic ☐ Massage ☐ Other____

SECONDARY COMPLAINT _____

Date of Onset & Cause of Complaint _____

Prior Intervention ☐Prescription drugs ☐Non-prescription drugs ☐ Physical therapy ☐ Surgery ☐ Acupuncture ☐ Chiropractic ☐ Massage ☐ Other____

ADDITIONAL COMPLAINT _____

Date of Onset & Cause of Complaint _____

Prior Intervention ☐Prescription drugs ☐Non-prescription drugs ☐ P T ☐ Surgery ☐ Acupuncture ☐ Chiropractic ☐ Massage ☐ Other_____

VAS Choose a number that best describes your pain. **NO PAIN < 1 2 3 4 5 6 7 8 9 10 > WORSE PAIN POSSIBLE**

How does your current condition interfere with:

Work or career: _____

Recreational activities: _____

Household Chores: _____

Personal Relationships: _____

Patient (or Guardian) Signature _____ Today's Date _____

REVIEW OF SYSTEMS Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please check all that apply to you – past or present.

MUSCULOSKELETAL ☐Osteoporosis ☐ Arthritis ☐ Scoliosis ☐ Neck/Back Pain ☐ Hip/Knee Pain ☐ Ankle/Foot Pain ☐ Shoulder Pain

NEUROLOGICAL ☐ Anxiety ☐Depression ☐ Headache ☐ Dizziness ☐ Pins and Needles ☐ Numbness

CARDIOVASCULAR ☐High Blood Pressure ☐ Low Blood Pressure ☐ Poor Circulation ☐ Angina ☐ Excessive Bruising

RESPIRATORY ☐Asthma ☐Apnea ☐Emphysema ☐Hay Fever ☐ Shortness of Breath ☐ Pneumonia

DIGESTIVE ☐ Anorexia/Bulimia ☐ Ulcer ☐ Food Sensitivities ☐ Heartburn ☐ Constipation ☐ Diarrhea

SENSORY ☐ Blurred Vision ☐ Ringing in Ears ☐ Hearing Loss ☐ Chronic Ear Infection ☐ Loss of Smell ☐ Loss of Taste

SKIN ☐ Skin Cancer ☐ Psoriasis ☐ Eczema ☐ Acne ☐ Hair Loss ☐ Rash

ENDOCRINE ☐ Thyroid Issues ☐ Immune Disorders ☐ Hypoglycemia ☐ Frequent Infection ☐ Swollen Glands ☐ Low Energy

GENITOURINARY ☐ Kidney Stones ☐ Infertility ☐ Bedwetting ☐ Prostate Issues ☐ Erectile Dysfunction ☐ PMS Symptoms

CONSTITUTIONAL ☐ Fainting ☐ Low Libido ☐ Poor Appetite ☐ Fatigue ☐ Sudden Weight Loss/Gain ☐ Weakness

PAST PERSONAL, FAMILY AND SOCIAL HISTORY Please check all that apply to you – past or present.

ILLNESSES ☐ Alcoholism ☐ Allergies ☐ Arteriosclerosis ☐ Cancer ☐ Chicken Pox ☐ Diabetes ☐ Epilepsy ☐ Glaucoma
☐ Goiter ☐ Gout ☐ Heart Disease ☐ Hepatitis ☐ HIV/AIDS ☐ Malaria ☐ Measles ☐ Multiple Sclerosis ☐ Mumps ☐ Polio
☐ Rheumatic Fever ☐ Scarlet Fever ☐ Sexually Transmitted Disease ☐ Stroke ☐ Tuberculosis ☐ Typhoid Fever ☐ Ulcer
☐ Other _____

OPERATIONS ☐ Appendix Removal ☐ Bypass Surgery ☐ Cancer ☐ Cosmetic Surgery ☐ Eye Surgery ☐ Hysterectomy
☐ Pacemaker ☐ Tonsillectomy ☐ Vasectomy ☐ Spine Surgery _____
☐ Elective Surgery _____ ☐ Other _____

TREATMENTS ☐ Acupuncture ☐ Antibiotics ☐ Blood Transfusions ☐ Chemotherapy ☐ Chiropractic Care
☐ Dialysis ☐ Herbs ☐ Hormone Replacement ☐ Inhaler ☐ Massage Therapy ☐ Physical Therapy ☐ Medications
☐ List all prescriptions, over-the-counter, natural supplements, vitamins, minerals _____

INJURIES Have you ever…
☐ Had a fractured or broken bone ☐ Had a spine or nerve disorder ☐ Been Knocked Unconscious ☐ Been injured in an accident
☐ Used a crutch or other support ☐ Used neck or back bracing ☐ Received a tattoo ☐ Had a body piercing

FAMILY HISTORY Some health issues are inherited. Please tell Dr. Hall about the health of your immediate family members.

Relative	Age	Health **G**ood/Bad	Illnesses	Age at Death	Cause of Death Natural/**I**llness
Mother					
Father					
Sister 1					
Sister 2					
Brother 1					
Brother 2					

Patient(or Guardian) Signature _____ Today's Date _____

SOCIAL HISTORY

	Daily	Weekly	How Much			Yes	No
Alcohol Use					Prayer/Meditation		
Coffee Use					Job Pressure / Stress		
Tobacco Use					Financial Peace		
Exercise					Vaccinated		
Pain Relievers					Mercury Fillings		
Soft Drinks					Recreational Drugs		
Water Intake							

ACTIVITIES OF DAILY LIVING How does this condition currently interfere with your life and ability to function?

	Sitting	Rising from Chair	Standing	Walking	Lying Down	Bending Over	Climbing Stairs	Using Computer	Getting in or out of Car	Driving a Car	Looking over Shoulder	Caring for Family
No Effect												
Mild Effect												
Moderate Effect												
Severe Effect												

	Grocery Shopping	Household Chores	Lifting Objects	Reaching Overhead	Showering or Bathing	Dressing Myself	Love Life	Getting to Sleep	Staying Asleep	Concentrating	Exercising	Yard Work
No Effect												
Mild Effect												
Moderate Effect												
Severe Effect												

Acknowledgements To set clear expectation, improve communication and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ Initials

I instruct Dr. Hall to deliver the care that, in his professional judgement, can best help me in the restoration of my health. I understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct body posture and motion thus reducing many symptoms. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. I certify that no guarantee or assurance has been made to the results that may be obtained.

_____ Initials

I authorize Dr. David Hall and whomever he may designate as his assistant to perform diagnostic tests and to administer treatment deemed necessary to treat my problem (illness). I understand that diagnostic X-rays may be advisable in my case so that a complete analysis can be made of my problem. I authorize Dr. Hall to perform such x-ray exams necessary to diagnose my present condition. I realize that X-ray may be hazardous to an unborn child and I certify to the best of my knowledge that I am NOT pregnant.

_____ Initials

I grant Hall Chiropractic permission to send and/or receive my complete patient file, including information relating to any medical history, mental or physical condition and any treatment received by me for the purpose of consultation with, collaboration with or transfer of care to another health care provider.

_____ Initials

I grant permission to be contacted to confirm or reschedule an appointment and to be sent occasional correspondents to me as an extension of my care in this office. I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ Initials

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will help prepare 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 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.

_____ Initials

I authorize Hall Chiropractic to release my medical information necessary to process my insurance and/or personal injury claim(s) and also certify that all insurance information I give to Hall Chiropractic is correct and complete.
I authorize any and all insurance companies and/or attorney to pay directly to Hall Chiropractic, 1171 Market Street, Fort Mill SC 29708. The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given limited power of attorney to endorse/sign my name to any and all drafts of payment of my bill.

Patient (or Guardian) Signature _____ Today's Date _____

HEAD

Headache
Frequency_____
Migraine
Head feels heavy
Loss of memory
Light-headedness / Fainting
Loss of balance dizziness

NECK

Pain in neck
Neck pain with movement
Muscle spasms in neck
Grinding/popping sounds in neck

SHOULDERS

Pain in shoulder (R – L)
Pain across shoulders
Painful to raise arm (R – L)

ARMS & HANDS

Pain in arm (R – L)
Fingers go to sleep (R – L)
Tingling in: arm (R – L)
hand (R – L)
fingers (R –L)
Numbness in: arms (R –L)
fingers (R – L)
Hand feels cold (R – L)
Loss of grip (R – L)

MID-BACK

Mid back pain
Pain between shoulders
Pain from front to back

CHEST

Chest pain
Shortness of breath
Pain around ribs

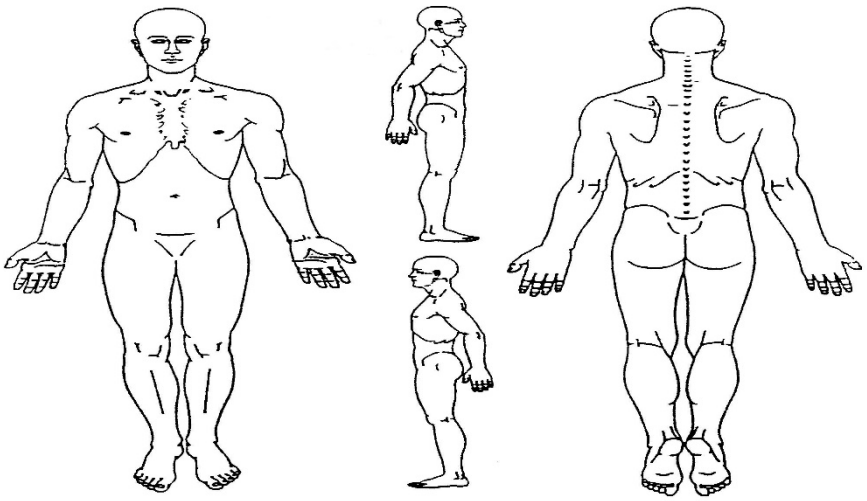
LOW BACK

Low back pain
Muscle spasm
Low back pain worse when…
Standing
Sitting
Lying down
Getting up / down
Walking
Lifting
Bending
Pain better when _____
Pain worse when _____

LEGS, KNEES, FEET

Buttock pain (R – L)
Hip joint pain (R - L)
Leg pain (R – L)
Knee pain (R – L)
Foot pain (R – L)
Tingling in leg/foot (R– L)
Numbness in leg (R – L)
Tingling in foot/toes (R – L)
Numbness in foot/toes (R – L)
Feet feel cold
Swollen ankle / foot (R – L)

PLEASE CIRCLE AREAS OF SYMPTOMS BELOW



Patient (or Guardian) Signature _____ Today's Date _____

Hall Chiropractic 1171 Market Street, Suite 104 Fort Mill SC 29708 803.412.2240