# HALL CHIROPRACTIC CENTER

**1171 Market Street Suite 104 Fort Mill, SC 29708 Phone 803.412.2240 Fax 803.802.4213**


Name _____ Today's Date: _____

Address _____ City _____ State _____ Zip _____

Phone Numbers (cell) _____ (home) _____ Sex M / F Marital Status S / M

Email _____ SS # _____ Birth date _____ Age ____

Occupation _____ Employer _____ Work # _____

Spouse's Name _____ Employer _____ Cell # _____

Emergency Contact _____ Cell# _____

Insurance Carrier _____ Primary Insured _____

Supplemental Ins. (Aflac) _____ Referred by _____

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WHAT IS YOUR MAJOR COMPLAINT _____
Other Complaints _____

How long have you had this condition? _____ Have you had similar complaints before? _____

What activities aggravate your condition? _____

The problem is getting: Worse / Better / Same / Comes and Goes How long since you felt really well? _____

List surgical procedures: _____

Prescription / Non-prescription drugs _____

Other doctors seen for this condition _____

Diagnosis _____ Scans/Tests (x-ray, MRI, blood…) _____

Treatment _____ Outcome _____

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ACCIDENT INFORMATION (if applicable) Date of Accident _____

Did your accident occur at work? Y / N Name of supervisor accident reported to: _____
Were you involved in an automobile collision? Y / N Location of incident _____

Was a police report filed? Y / N Description of incident _____

Describe your injuries _____

Were you taken to the hospital Y / N Which Hospital _____

Attorney name/phone/address _____

I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. If my account becomes more than 30 days delinquent, I may be held liable for a delinquency fee of 1½ % of the declining balance each month until account is paid in full. I also understand that if I suspend or terminate my care and treatment, any fees for professional services and goods rendered to me will be immediately due and payable. I also authorize any third party payor to pay funds directly to Hall Chiropractic Center.

X Patient's Signature _____ Date _____

**HEAD:**
- Headache
  - Frequency_____
  - Sinus (allergy)
  - Entire head
  - Back of head
  - Forehead
  - Temples
- Migraine
- Head feels heavy
- Loss of memory
- Light-headedness / Fainting
- Light bothers eyes
- Blurred / Double vision
- Loss of vision
- Loss of taste
- Loss of balance dizziness
- Loss of hearing
- Ringing / buzzing in ears

**NECK:**
- Pain in neck
- Neck pain with movement:

Forward
Backward
Turn to left
Turn to right
Bend to left
Bend to right

- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

**SHOULDERS:**
- Pain in shoulder ( R – L)
- Pain across shoulders
- Can't raise arm ( R – L)
  - Above shoulder level
  - Overhead

**ARMS & HANDS:**
- Pain in upper arm ( R – L)
- Pain in elbow ( R – L)
- Tennis elbow ( R – L)
- Carpal Tunnel ( R – L)
- Pain in forearm ( R – L)
- Pain in hand ( R – L)
- Pain in fingers ( R – L)
- Fingers go to sleep ( R – L)
- Tingling in arm ( R – L)
- Tingling in fingers ( R – L)
- Numbness in arms ( R – L)
- Numbness in fingers ( R – L)
- Hand feels cold ( R – L)
- Swollen joints in fingers ( R – L)
- Arthritis in fingers ( R – L)
- Loss of grip strength ( R – L)

**MID-BACK:**
- Mid back pain
- Pain between shoulder blades
- Sharp stabbing pain
- Dull ache
- Pain from front to back
- Pain in kidney area

**CHEST:**
- Chest pain
- Shortness of breath
- Pain around ribs

**ABDOMEN:**
- Foods can't eat _____
  _____
- Nausea
- Gas
- Constipation
- Diarrhea

**LOW BACK:**
- Low back pain
- Upper lumbar pain
- Lower lumbar pain
- Sacroiliac pain
- Slipped disc
- Herniated disc
- Muscle spasm
- Arthritis

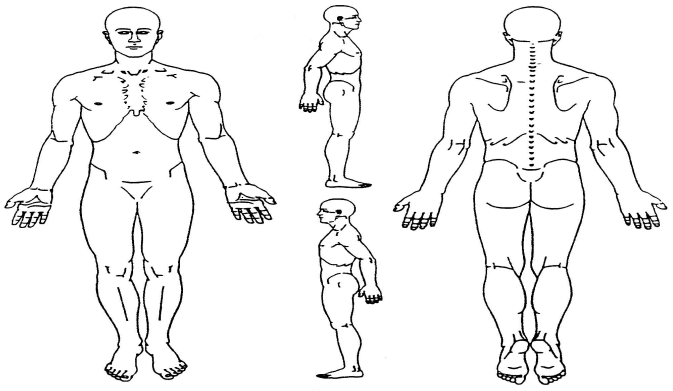
Low back pain worse when…
- Working
- Walking
- Lifting
- Getting up / down
- Standing
- Sitting
- Bending
- Coughing
- Lying down
- Sleeping

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)

**GENERAL:**
- Muscle Cramps
- Nervousness
- Irritable
- Depressed
- Fatigue
- Sleep _____ hours
- Weight gain / loss
- Diabetes

***PLEASE CIRCLE AREAS OF SYMPTOMS BELOW***



**X** Patient Signature _____

# AUTHORIZATIONS AND RELEASES

**HALL CHIROPRACTIC CENTER, 1171 MARKET STREET, SUITE 104, FORT MILL, SC 29708**

**Name: _____Patient #_____**

## Consent for Treatment

I, the undersigned authorize Dr. David Hall and his assistants to perform diagnostic tests and to administer necessary treatment. I also certify that no guarantee or assurance has been made to the results of my care.

I understand that diagnostic x-rays may be advisable in my case so that a complete analysis can be made of my present musculoskeletal problem (or illness). I authorize Dr. David Hall / Hall Chiropractic Center to perform such X-rays necessary to diagnose my present condition or illness. ***If female, to the best of my knowledge I am NOT pregnant I give Dr. David Hall permission to X-ray me for diagnostic interpretation.

Patient's Signature_____Date_____

## Authorization to Release Medical Information

I authorize Hall Chiropractic Center to release of 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 Center is correct and complete.

I also authorize Hall Chiropractic Center to receive copies of all records and reports and all records and any other they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward this to Hall Chiropractic Center, 1171 Market Street, Suite 104, Fort Mill, SC 29708.

Patient Signature_____Date_____

## Request for Payment of Benefits to Hall Chiropractic Center

I hereby authorize any related insurance company / administrator to pay directly to Hall Chiropractic Center the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I agree to pay in a current manner any balance of said applicable charges. I authorize that Hall Chiropractic Center be given limited power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office may 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. 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's Signature_____Date_____

## Consent for Treatment of Minor

I hereby authorize Dr. David Hall and whomever he may designate as his assistant(s) to perform diagnostic tests and to administer treatment as is deemed necessary to the below mentioned patient. I also authorize the release of my dependent's records which are a part of the records of Hall Chiropractic Center.

Child's name: _____

Guardian's Signature_____ Date_____