CONFIDENTIAL HEALTH INFORMATION

Please Complete ENTIRE Form

Patient Name_____ Nickname _____ Age ____ Gender ____

Guardian (if minor) _____ SS # _____

Address _____ City _____ State ____ Zip _____

Phone (cell) _____ Email _____Birthdate _____

Race ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Decline to answer ☐ Other_____

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 _____

Pain Quality: Intermittent / Constant / Mild / Moderate / Severe / Dull / Sharp / Stabbing / Throbbing / Shooting / Burning / Numb

Prior Intervention ☐ Prescription drugs ☐ Over the Counter drugs ☐ Physical therapy ☐ Surgery ☐ Chiropractic ☐ Massage ☐ Other_____

SECONDARY COMPLAINT _____

Date of Onset & Cause of Complaint _____

Pain Quality: Intermittent / Constant / Mild / Moderate / Severe / Dull / Sharp / Stabbing / Throbbing / Shooting / Burning / Numb

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

ADDITIONAL COMPLAINTS _____

How does your current condition interfere with:

Work or career: _____

Recreational activities: _____

Household Chores: _____

Personal Relationships: _____

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: arm (R – L)
hand (R – L)
fingers (R – L)
Hand feels cold (R – L)
Loss of grip strength (R – L)

MID-BACK:
Mid back pain
Pain between shoulders
Pain from front to back

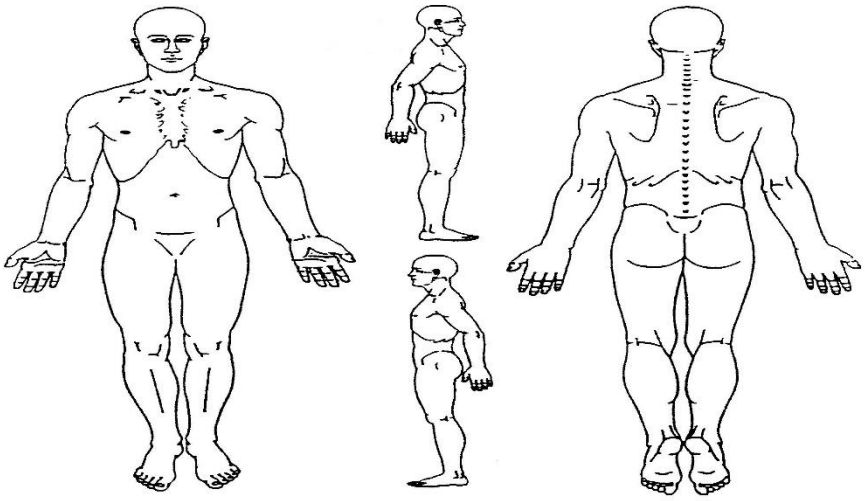
CHEST:
Chest pain
Shortness of breath
Pain around ribs

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…_____
_____

LEGS, KNEES, FEET:
Buttock pain (R – L)
Hip joint pain (R – L)
Leg pain (R – L)
Knee pain (R – L)
Foot/ankle pain (R – L)
Tingling in: leg (R – L)
foot (R – L)
toes (R – L)
Numbness in: leg (R – L)
foot (R – L)
toes (R – L)
Foot feels cold (R – L)

Other Concerns:_____
_____

PLEASE CIRCLE AREAS OF SYMPTOMS BELOW



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

REVIEW OF SYSTEMS: Please check all that apply to YOU – past or present.

CONSTITUTIONAL	☐ Fainting ☐ Low Libido ☐ Poor Appetite ☐ Fatigue ☐ Sudden Weight Loss/Gain ☐ Weakness
EYES	☐ Jaundice ☐ Vision Problem ☐ Discharge ☐ Redness ☐ Soreness ☐ Swelling ☐ Tearing ☐ Glaucoma
EarNoseThroat	☐ Congestion ☐ Hearing Loss ☐ Ringing ☐ Sinusitis ☐ Discharge ☐ Bleeding Gums ☐ Dental Problem
CARDIOVASCULAR	☐ High Blood Pressure ☐ Low Blood Pressure ☐ Poor Circulation ☐ Angina ☐ Excessive Bruising
RESPIRATORY	☐ Asthma ☐ Apnea ☐ Emphysema ☐ Hay Fever ☐ Shortness of Breath ☐ Pneumonia
GASTROINTESTINAL	☐ Anorexia/Bulimia ☐ Ulcer ☐ Food Sensitivities ☐ Heartburn ☐ Constipation ☐ Diarrhea
GENITOURINARY	☐ Kidney Stones ☐ Infertility ☐ Prostate Issues ☐ Erectile Dysfunction ☐ PMS Symptoms
MUSCULOSKELETAL	☐ Osteoporosis ☐ Arthritis ☐ Scoliosis ☐ Joint Pain
SKIN	☐ Skin Cancer ☐ Psoriasis ☐ Eczema ☐ Acne ☐ Hair Loss ☐ Rash
PSYCHIATRIC	☐ Fainting ☐ Low Libido ☐ Poor Appetite ☐ Fatigue ☐ Sudden Weight Loss/Gain ☐ Weakness
NEUROLOGICAL	☐ Anxiety ☐ Depression ☐ Headache ☐ Dizziness ☐ Pins and Needles ☐ Numbness
ENDOCRINE	☐ Thyroid Issues ☐ Immune Disorders ☐ Hypoglycemia ☐ Frequent Infection ☐ Swollen Glands
HEMOTOLOGIC	☐ Fainting ☐ Low Libido ☐ Poor Appetite ☐ Fatigue ☐ Sudden Weight Loss/Gain ☐ Weakness

PAST PERSONAL /MEDICAL / 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 ☐ Other Surgery _____

☐ List all medications and supplements_____

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

Relative	Age	Health Good/Bad	Illnesses	Age at Death	Cause of Death
Mother					
Father					
Sibling 1					
Sibling 2					
Sibling 3					

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?

	VIGOROUS ACTIVITY Running Heavy Lifting Strenuous Sports	MODERATE ACTIVITY Moving Table Vacuuming Bowling / Golfing	Lifting or carrying groceries	Climbing several flights of stairs	Climbing one flight of stairs	Bending, kneeling or stooping	Walking more than one mile	Walking several blocks	Walking one block	Bathing or dressing self
No Effect										
Mild Effect										
Moderate Effect										
Severe Effect										

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

Acknowledgements To set clear expectations, improve communication and help 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 or receive my complete patient file for the purpose of consultation, collaboration or referral to another health care provider including medical history, mental or physical condition and any treatment received by me.

_____ Initials
I grant permission to be contacted via email or text 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 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 given to Hall Chiropractic is correct and complete. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that as a courtesy to me, this office may help prepare necessary reports and forms to assist me in making collection from the my insurance and/or personal injury claim(s) 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 any and all insurance companies and/or attorneys 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.

INFORMED CONSENT

The Nature of the Chiropractic Adjustment The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Palpation	Orthopedic testing	Massage therapy
Range of motion testing	Vital signs	Basic neurological testing	Mechanical traction
Muscle strength testing	Postural analysis	Exercise therapy	Radiographic studies

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options. Other treatment options for your condition may include:
Hospitalization Self-administered, over-the-counter analgesics and rest Surgery Medical care and prescription drugs

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read and understand the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

PATIENT NAME: _____ DATE: _____

PATIENT / PARENT / GUARDIAN SIGNATURE: _____