CONFIDENTIAL HEALTH HISTORY

Please fill out the following information to the best of your knowledge to help us understand your condition fully and determine if we can help you. All information provided is considered confidential and will only be released by written consent of patient or guardian of patient. Thank you for entrusting us with your care.

NAME_____ MALE/FEMALE DATE_____
ADDRESS_____CITY_____STATE_____ZIP_____
AGE_____ DATE OF BIRTH_____
MARTIAL STATUS: S/M/D/W #CHILDREN_____ EMAIL_____
HOME#_____CELL#_____ OTHER #_____
WOULD YOU LIKE APPOINTMENT REMINDERS? YES or NO IF YES, REMINDER PREFERENCE: TEXT or EMAIL
EMPLOYER_____ OCCUPATION_____ WORK #_____
SPOUSE/GUARDIAN_____ CELL/WORK #_____
EMERGENCY CONTACT_____ CELL/WORK #_____
HOW DID YOU HEAR ABOUT OUR OFFICE?_____

GENERAL HEALTH HISTORY

HEIGHT_____ WEIGHT_____ PRIMARY CARE PHYSICIAN_____

DO YOU SMOKE OR USE TOBACCO (packs/day)?_____ DO YOU EXERCISES(days/week)?_____

ARE YOU PREGNANT?_____ IF YES, DUE DATE_____

HOSPITIALIZATIONS/ SURGERIES/OPERATIONS_____

PRIOR ACCIDENTS/INJURIES_____

ALLERGIES_____

CURRENT MEDICATIONS_____

CURRENT SUPPLEMENTS_____

RECENT IMAGING (XRAY, MRI, CT scan) within last year. Please provide date and body area:

_____

HAVE YOU BEEN DIAGNOSED WITH OR SUFFER FROM ANY OF THE FOLLOWING? ("x" what applies)

__HIGH BLOOD PRESSURE	__ANEMIA	__OSTEOPOROSIS	__SCIATICA
__LOW BLOOD PRESSURE	__ASTHMA	__OSTEOPENIA	__NECK PAIN
__HEART TROUBLE	__HIV/AIDS	__MUSCLE PAIN	__HEADACHES
__DIABETES	__HIGH CHOLESTEROL	__JOINT PAIN	__LOW BACK PAIN
__PACEMAKER	__FIBROMYALGIA	__NERVE PAIN	__OTHER_____
__TIA/STROKE	__NEUROPATHY	__FIBROMYALGIA	
__CANCER	__SHINGLES		

[**CONTINUED ON BACKSIDE]**

PREVIOUS BACK PROBLEMS (explain) _____

_____

PREVIOUS CHIROPRACTIC CARE (date, doctor, condition treated)_____

PREVIOUS ACUPUNCTURE CARE (date, doctor, condition treated)_____

REASON FOR VISIT (please describe complaint(s) in detail and in order of severity and importance)

1._____
2._____
3. _____

WHEN DID THIS CONDITION(S) START?_____
ARE YOU UNABLE TO DO ANY ACTIVITIES?_____ IF YES, EXPLAIN_____
DO YOU KNOW WHAT CAUSED THIS?_____
IS THE COMPLAINT RELATED TO AN AUTO ACCIDENT?_____ IF SO, PLEASE TELL OUR STAFF IMMEDIATELY.
IS THE COMPLAINT WORK RELATED?_____ IF SO, HAVE YOU INFORMED YOUR EMPLOYER?_____

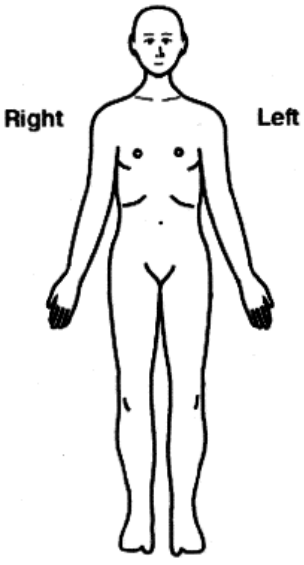
HAVE YOU BEEN TREATED FOR THIS PROBLEM?(when/where)_____
_____IF SO, DID THE TREATMENT HELP?_____

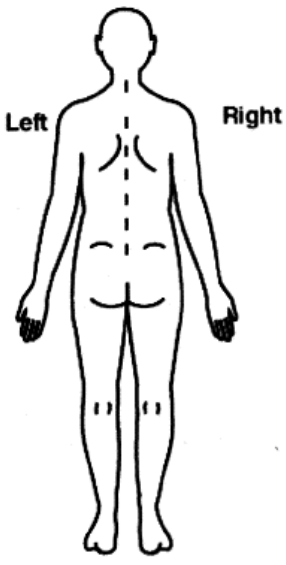
PAIN SCALE

Please circle the level that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

MILD MEDIUM SEVERE





Draw an "X" on the diagram to the left in the area of your complaint(s) and a letter describing

A=achy
B=burning
S=stabbing
N=numbness
T=tingling

_____

PATIENT/GUARDIAN SIGNATURE DATE

Patient Name_____ Date_____

REVIEW OF SYSTEMS

Please fill out to the best of your knowledge based on your current health history.
Circle any symptoms that describe you.

General
Leathery/Weakness
Recurring Fever
Recent weight gain/loss
Dizziness
Fever
Chills
Other_____

HEENT
Headaches
Visual Changes
Sinus problems
Nose bleeds
Hearing loss
Ear pain
Ringing in ears
Sore throat
Hoarseness
Swollen Glands
Bleeding gums

Other_____

Skin/Hair
Rashes
Itching
Lesions
Hives
Psoriasis
Mole changes
Changes in skin color
Change in hair
Nail problems
Other_____

Respiratory
Chronic/frequent cough
Spitting up blood
Asthma/wheezing
Shortness of breath
Exercise intolerance
Sleep Apnea
Emphysema
Other_____

Gastrointestinal
Loss of appetite
Nausea or vomiting
Diarrhea
Constipation
Abdominal Pain
Stomach Ulcer
Bloating/Cramping
Heartburn
Rectal Bleeding
Hemorrhoids

Hepatitis

Cirrhosis
Other_____

Cardiovascular
Chest pain
Heart attack
Shortness of breath
Palpitations
Swelling of feet or hands
High blood pressure
High cholesterol
Heart murmur
Blood clots
Pacemaker

Mitral Valve Prolapse

Other_____

Musculoskeletal
Arthritis
Muscle pain
Muscle cramps
Muscle stiffness
Joint pain/swelling
Neck pain
Back pain
Other_____

Blood Lymph
Anemia
Bleeding
Bruising
Blood clots
Past transfusions
Leukemia
Lymphoma
HIV/AIDS
Sickle Cell
Other_____

Allergies
Seasonal
Medication
Food
Other_____

Urinary
Frequent Urination
Burning/painful urination
Incontinence
Hesitancy
Urgency
Blood in Urine
Other_____

Psychiatric
Alzheimer's Disease
Insomnia
Difficulty concentrating
Memory loss/confusion
Depression
Anxiety
Suicidal thoughts
Chemical dependency
Other_____

Endocrine
Diabetes
Thyroid Disease
Sweating
Heat Intolerance
Cold intolerance
Weight gain/loss
Frequent Urination
Excessive thirst
Change in appetite
Hair Changes

Other_____

Neurological
Frequent headaches
Migraines
Dizziness
Fainting
Memory loss
Poor Balance
Numbness/tingling
Pins/needles
Limb weakness
Seizures
Stroke
Tremors
Head injury

Other_____

SOUTHALL CHIROPRACTIC, PLLC

POLICY

PAYMENT FOR SERVICE: Payment is due at the time of service by Cash, Check, Debit/Credit/HSA Card. There is a 4% processing fee on any card purchase (debit/credit/HSA).

INSURANCE: We are currently not in network with any form of commercial health insurance. We will gladly provide a receipt with coding to patient to file claims their selves. Please allow 2-3 business days to receive courtesy receipt.

MEDICARE: Dr. Southall is a **non-participating** Medicare provider**. Other providers in office are not in network as Medicare providers.** Patients are responsible for paying up front for services (examinations, treatment, therapies), and Medicare will reimburse patient after claims are filed (usually 30-90 days). Secondary insurances are automatically filed through Medicare.

ADDITIONAL FEES: A no call/no show fee of $30 will be charged to any patient who does not cancel their scheduled appointment within 12 hours of appointment time. Acceptable forms of cancellation are by telephone or responding to text message reminder day BEFORE appointment only. Unacceptable forms of cancellation are by email, text message, Facebook, or any other form of social media.

MEDICAL RECORDS: Any request for medical records by the patient will be mailed, faxed, or picked up in person. Please allow 10 days to receive these records or reports. There will be a $50 charge for 1st 10 pages of all medical records plus $1 for each additional page. There will be a $50 charge for requested letters for VA disability ratings.

Patient Signature_____ **Date** _____

SOUTHALL CHIROPRACTIC, PLLC

CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

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

Patient Signature_____ Date _____

ACUPUNCTURE/DRY NEEDLING CONSENT

If applicable to my case, I authorize performance of chiropractic acupuncture or dry needling therapy. Both therapies use sterile, one time use, stainless steel needles. Chiropractic acupuncture is a form of Chinese Medicine used to treatment musculoskeletal complaints. Dry needling is a medical treatment targeting trigger points in muscles that relies on medical diagnosis to be effective. While complications of both are rare in occurrence, they are real and must be considered prior to treatment. The most serious risk of both is accidental puncture of the lung (pneumothorax). If this were to occur, it may require a chest xray and further medical treatment. Other risks include injury to a blood vessel causing bruising, infection, and/or nerve injury. Bruising is common and should not be a concern. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.

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

Patient Signature_____Date_____

SOUTHALL CHIROPRACTIC, PLLC

HIPPA

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

I have read and agree to the above policies and understand my right to protect my privacy.

Patient Signature:_____**Date:**_____

Please list names of family members and physicians we are ALLOWED to share your information with. If someone outside of this list contacts our office on your behalf, we will be unable to speak to them about you or allow them to schedule your appointments.

Name_____Phone Number :_____

Name_____Phone Number :_____

Name_____Phone Number :_____

Name_____Phone Number :_____