South Hill Structural Integration

Postural Change for Optimal Health

Patient Information

Your Name (patient) _____ Birthdate _____ Date _____

Parent or Guardian Name (if patient is under 18) _____

Address (mailing) _____ City_____ State ____ Zip Code _____

Telephone (home) ☐ _____ (work) ☐_____ (cell) ☐ _____

Please check preferred number. May we leave a confidential voice mail at this number? Yes ☐ No ☐

Email address _____ Employer _____ Position _____

Emergency Contact _____ Relation to Patient _____ Phone _____

Billing Information- for Automobile or Work Related Injuries

Insurance Company _____ Plan Name _____

Insurance Address _____ Insurance Phone _____

Group Number _____ ID Number _____

Subscriber Name _____ Date of Birth _____

Secondary Insurance? _____

Is your visit due to a recent accident? Yes ☐ No ☐ (If so, please provide proper insurance information)

Billing Information _____

CONFIDENTIALITY:
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

I understand that a record will be kept of the health services provided to me.This record will be kept confidential and will not be released to others unless so directed by my lawful representative, or me, or unless law permits or requires it. I understand that South Hill Structural Integration (SHSI) will use and disclose health information about the patient in compliance with the HIPAA Act. I understand I am entitled to receive a copy of the Notice of Privacy Policy as outlined by Federal Regulations. I have the right to ask that some or all of the patient's health information may not be used or disclosed in the manner described in the Notice of Privacy Practices. I also understand SHSI is not required by law to agree to such requests. My signature below acknowledges I am aware of my rights in accordance to HIPAA.

INITIAL THAT YOU WERE OFFERED A NOTICE OF PRIVACY PRACTICES:_____
RELEASE OF HEALTH INFORMATION: SHSI keeps a record of the health care services we provide me or my child. I may ask to see and copy that record (copy charges may apply). I may ask us to correct that record. If I would like that record sent to another provider, my request to South Hill Structural Integration must be made in writing.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE INFORMATION ABOVE. I UNDERSTAND I WILL BE FINANCIALLY RESPONSIBLE FOR SERVICES THAT MY INSURANCE COMPANY INDICATES ARE "PATIENT RESPONSIBILITY."

Patient/Parent/Guardian Signature_____ _____ Date_____

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Health History

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____ ☐R ☐L Handed

Occupation: _____ Primary Care Physician: _____

Phone: _____

Please identify your primary health concerns in the order of severity:

Include the Onset or Known Cause and Previous Treatment(s)

_____

_____

_____

Is this related to an Automobile Accident?_____

Are we billing your Auto Insurance for your Treatments?_____

To what extents do the health concerns affect your daily activities (work, sleep, etc.)?

_____

_____

_____

If you have been given a diagnosis for your health concern(s), please describe the diagnoses below and indicate who made the diagnosis.

_____

_____

_____

Please list all other medications or supplements you have taken over the last three months:

Medication/supplement, the Reason for taking it and the Dosage/ Frequency

_____

_____

_____

Women

Current Contraception: _____ Are you currently pregnant? □ Yes □ No □ Maybe

Due Date_____ Number of Pregnancies_____ Deliveries _____

_____

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Are any of the following applicable to you?

□ Surgeries, (including cosmetic) – types and date (s):

_____

_____

_____

□ Significant Trauma – auto accidents, falls, etc.:

_____

_____

_____

_____

□ Significant Dental Work – types and date (s):

_____

□ Occupational or Emotional Stress – Chemical, physical, psychological:

_____

Please describe your exercise program:

_____

_____

Please describe your average daily diet/routine:

Morning:_____

Afternoon: _____

Evening: _____

Average Daily Water Consumption _____ (in number of glasses or ounces).

What are your Goals for your Structural Integration sessions?

_____

_____

_____

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