WELCOME TO BRADY CHIROPRACTIC GROUP, PC

File # _____ Date _____

PATIENT INFORMATION

Thank you for choosing our practice for your Chiropractic needs. For us to understand your condition properly, please be as accurate as possible while completing this form. If you have any questions or concerns, please ask for assistance. We will be happy to help you. Thank You.

Name _____ Date of Birth _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Birth Sex: ☐ Female ☐ Male

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Primary Language _____

Are you: ☐ Minor ☐ Single ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Separated ☐ Widow

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic

☐ Native Hawaiian or Other Pacific Islander ☐ White

Your Occupation _____ Your Employer _____

Emergency Contact _____ Phone Number _____

Name of person responsible for this account if other than the patient? _____

Address _____ City _____ State _____ Zip _____

Phone _____ Relationship _____

Whom may we thank for referring you to us? _____

AUTHORIZATION FOR PAYMENT / FINANCIAL AGREEMENT

I understand that **BRADY CHIROPRACTIC GROUP, PC** bills my insurance as a service to me. I understand that it is my responsibility to ensure that my insurance carrier processes all claims. I understand that I am personally responsible for all charges whether or not paid by my insurance carrier.

I agree to pay my deductible, co-pay or co-insurance at the time of service. I agree that if payment is not made in the agreed upon manner I will pay interest on said account at the rate of 1.5 % per month on the unpaid balance (18% per annum)

_____ _____

PATIENT
PARENT OR GUARDIAN SIGNATURE

DATE

WELLNESS

Tobacco use: ☐ Never Smoked ☐ Former tobacco user ☐ Live with a smoker

☐ Current every day tobacco use ☐ Current occasional tobacco user

Alcohol consumption: ☐ None ☐ Rarely ☐ Social Drinker ☐ Recovering Alcoholic

Caffeine consumption: ☐ None ☐ Rarely ☐ Frequently -- ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks

HEALTH HISTORY

Cancer ☐ **Yes** ☐ **No** What kind? _____

High blood pressure	☐ **Yes** ☐ **No**	Mental Illness	☐ **Yes** ☐ **No**
Heart Disease	☐ **Yes** ☐ **No**	Losing weight now without trying	☐ **Yes** ☐ **No**
High cholesterol	☐ **Yes** ☐ **No**	Lost consciousness	☐ **Yes** ☐ **No**
Pacemaker	☐ **Yes** ☐ **No**	Loss of bladder or bowel control	☐ **Yes** ☐ **No**
Stroke	☐ **Yes** ☐ **No**	Noticing blood in stool or urine	☐ **Yes** ☐ **No**
Diabetes ☐ **Yes** ☐ **No** Type 1 (Insulin) Type 2		Coughing up blood	☐ **Yes** ☐ **No**
Osteoporosis	☐ **Yes** ☐ **No**	Recent episodes of weakness	☐ **Yes** ☐ **No**
Fibromyalgia	☐ **Yes** ☐ **No**	Recent double vision	☐ **Yes** ☐ **No**
Rheumatoid Arthritis	☐ **Yes** ☐ **No**	Recent dental work ☐ **Yes** ☐ **No** _____	
Thyroid disease	☐ **Yes** ☐ **No**	Joint replacements ☐ **Yes** ☐ **No** _____	
Implants of any kind	☐ **Yes** ☐ **No**	Surgeries ☐ **Yes** ☐ **No** _____	
Fractures ☐ **Yes** ☐ **No** _____		_____	

Other Medical or Health Concerns: _____

_____

Name of primary physician _____ **Specialists** _____

Are you currently taking any medications? ☐ **Yes** ☐ **No** **If yes, please continue.**
Medications / prescribed and over the counter: Please allow us to make a copy of the list you carry with you.

_____ _____ _____

_____ _____ _____

_____ _____ _____

What vitamins or other nutritional supplements do you currently take?

_____ _____ _____

_____ _____ _____

Do you have any medication allergies? ☐ **Yes** ☐ **No** _____

FEMALES ONLY

Is there any chance that you are pregnant now? ☐ Yes ☐ No _____

Date of last menstrual cycle _____ How many children? ___ Vaginal birth ___ C-section ___

Pregnancy complications? ☐ Yes ☐ No _____

Have you had a bone density scan? ☐ Yes ☐ No Month _____ Year_____

CURRENT CONCERNS

PRIMARY CONCERN: ◊ Neck pain ◊ Low back pain ◊ Back pain ◊ Headache ◊ Other

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WHAT CAUSED THE PAIN? ◊ Trauma ◊ Fall ◊ Unknown ◊ Other

WHEN DID THE PAIN START? _____ day(s) _____ week(s) _____ month(s) _____ year(s)

WHAT HELPS THE PAIN? Mark all that apply.

◊ ice ◊ heat ◊ stretching ◊ massage ◊ medication ◊ nothing ◊ other _____

WHAT AGGRAVATES THE PAIN? Mark all that apply.

◊ movement ◊ sitting ◊ standing ◊ walking ◊ driving ◊ lifting ◊ sleeping ◊ other _____

HOW WOULD YOU DESCRIBE THE PAIN? Mark all that apply.

◊ dull ◊ sharp ◊ tingling ◊ burning ◊ stabbing ◊ throbbing ◊ squeezing ◊ Other _____

WHERE DOES THE PAIN RADIATE? Mark all that apply.

◊ N/A ◊ R arm ◊ L arm ◊ R leg ◊ L leg ◊ R buttocks ◊ L Buttocks ◊ R hand/fingers ◊ L hand/ fingers

HOW SEVERE IS THE PAIN? 0 1 2 3 4 5 6 7 8 9 10

No Pain Severe Pain

HOW OFTEN DO YOU FEEL THE PAIN? ◊ Constant ◊ daily ◊ weekly ◊ monthly ◊ other _____

HAS THE PAIN IMPROVED SINCE IT STARTED? ◊ YES ◊ NO ◊ other _____

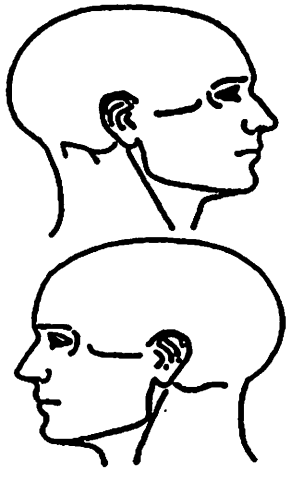
HAS THE PAIN WORSENED SINCE IT STARTED? ◊ YES ◊ NO ◊ other _____

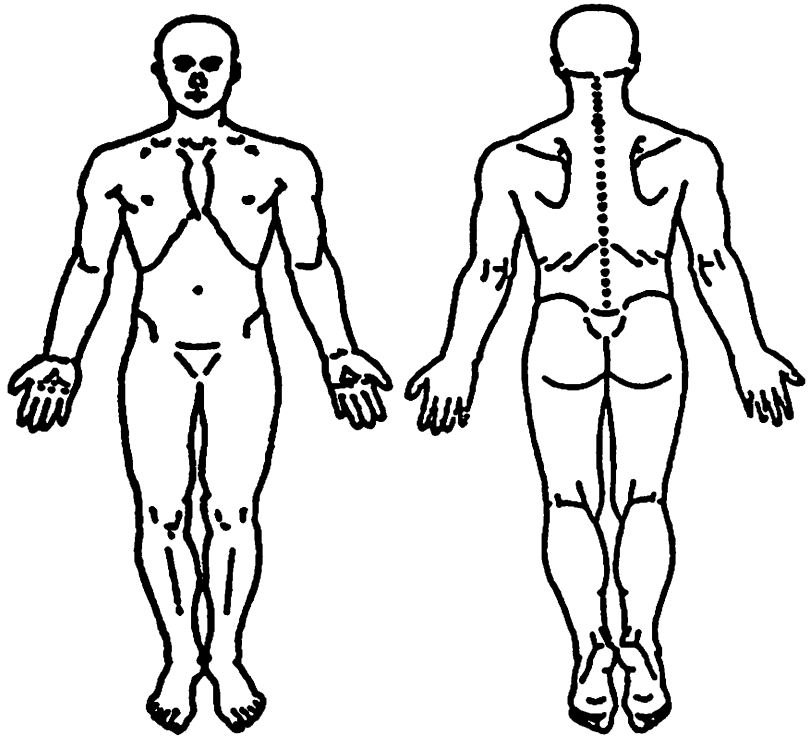
HAVE YOU HAD THIS TYPE OF PAIN BEFORE? ◊ YES ◊ NO ◊ other _____

HAVE YOU BEEN TREATED FOR THIS TYPE OF PAIN BEFORE? ◊ YES ◊ NO ◊ other _____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR?

Circle your areas of concern or the areas you would like to see improvement.





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