PATIENT INFORMATION

File # _____ Date _____

Patient Information

Thank you for choosing our practice for your Chiropractic needs. In order for us to understand your condition properly, please be as neat and 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 / Home Phone _____ Work Phone _____ 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

Emergency Contact _____ Phone Number _____

Your Occupation _____ Your Employer _____

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? _____

Insurance Information - Please provide us with your insurance card so we can make a copy.

Is this visit related to an accident?

Automobile ☐ Yes ☐ No Work Related ☐ Yes ☐ No Other ☐ Yes ☐ No

Date of injury _____ Time _____ Place _____

Insurance Company _____

Claim # _____ Adjuster Phone # _____

Health History

Please provide information on all that apply to you including year.

Cancer Yes/No What kind? _____

High blood pressure Yes / No _____ Diabetes Yes/No Type 1 (Insulin Dependent) Type 2

Heart Disease Yes / No What kind? _____ Stroke Yes / No _____

Fibromyalgia Yes / No _____ Rheumatoid Arthritis Yes / No _____

High cholesterol Yes / No _____ Thyroid Yes / No Explain _____

Osteoporosis Yes / No _____ Mental Illness Yes / No _____

Pacemaker Yes / No _____ Implants of any kind Yes / No _____

Losing weight now without trying Yes / No _____ Fractures Yes / No _____

Coughing up blood or noticing it in your stools or urine Yes / No _____

Loss of bladder or bowel control Yes / No _____ Recent episodes of weakness Yes / No _____

Lost consciousness Yes / No _____ Double vision recently Yes / No _____

Recent dental work Yes / No _____ Joint replacements Yes / No _____

Surgeries Yes / No _____

Other Medical or Health Issues: _____

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_____

Name of local primary physician _____ **Specialists** _____

Family Health History

List immediate family members that have these issues: M = mother P = father B = brother S = sister

MGM = maternal grandmother / MGF = maternal grandfather

PGM = paternal grandmother / PGF = paternal grandfather

Cancer Yes/No What kind?_____

_____

High blood pressure _____ Diabetes Yes/No Type 1 (Insulin Dependent) Type 2

Heart Disease Yes / No What kind? _____ Stroke _____

Fibromyalgia _____ Rheumatoid Arthritis _____

High cholesterol _____ Thyroid Yes/No What problems?_____

Osteoporosis _____ Mental Illness _____

Other _____

Wellness

Tobacco use:

Never Smoked Live with a smoker Current every day tobacco use Current occasional tobacco use

Former tobacco user / Quit Date _____ How long did you use? _____ years

Alcohol consumption: None Rarely Social Drinker Recovering Alcoholic

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

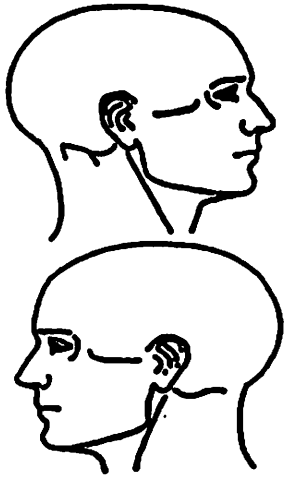
Hobbies / Activities of daily living _____

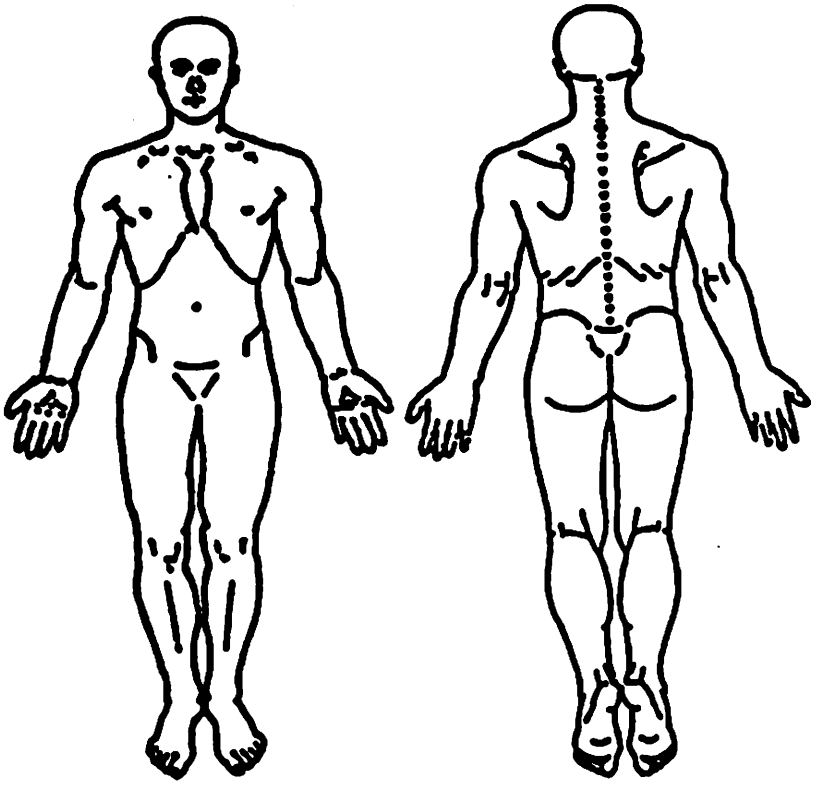
_____

_____

Circle area of complaint

Please mark the diagrams using
A = Ache
B = Burning
C = Stabbing
N = Numbing
P = Pins & Needles
M = Muscle Spasm
O = Other





Circle the number below to indicate the degree of pain and/or discomfort you are experiencing today.

Absence 0 1 2 3 4 5 6 7 8 9 10 Extreme

Are you interested in receiving more information on:

Massage therapy _____

Acupuncture _____

Custom Foot Orthotics _____

Nutritional Supplements _____

Other _____

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). Brady Chiropractic Group offers patients a discount if payment is made at the time of service. (This does not include the initial exam, x-rays, massage, supplements or supports.)

_____ _____ _____

PATIENT
PARENT OR GUARDIAN SIGNATURE

DATE

WITNESS SIGNATURE