Bradley Chiropractic Center
Patrick S. Bradley, DC

Chiropractic Intake and Health History Form

Date:_____

Patient Information

Name:_____
Address: _____
_____
City State Zip
Home Phone:_____ ❑Preferred #
Cell Phone:_____ ❑Preferred #
email:_____
Sex: ❑ M ❑ F Age_____ Birth Date:_____
Social Security #:_____
❑Single ❑Married ❑Widowed ❑Separated ❑Divorced
Occupation:_____
Employer:_____
Phone:_____ ❑FT ❑PT ❑Retired ❑UE
Whom May We Thank For Referring You To Our Office?
Name:_____

IN CASE OF EMERGENCY, CONTACT

Name:_____
Phone:_____ Alt #_____

Accident Information

Is condition due to an accident? ❑Y ❑N Date:_____
Type Of Accident: ❑Auto ❑Work ❑Home ❑Other
To whom have you reported this accident to?
❑Auto Insurance Co ❑Employer ❑Work Comp ❑Other

Payment/Insurance Information

❑ Auto Insurance Claim ❑ Commercial Insurance
❑ Worker's Compensation Claim ❑ Medicare
❑ No Insurance (Self Pay)
Insurance Co Name:_____
Name of Insured:_____
Relationship to Insured:_____
Insured's Date of Birth:_____
ID#_____ Group#_____
Insurance Phone:_____
Do you have Secondary Insurance Coverage? ❑Y ❑N
If this is a Commercial Insurance or Medicare Claim, please fill out the following "Assignment and Release"

Assignment and Release

I, the undersigned, certify that I (or my dependant) have the insurance coverage listed above and assign directly to Bradley Chiropractic Center, INC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I'm financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

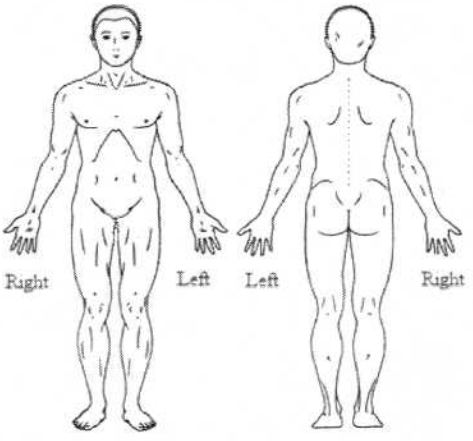
_____
Responsible Party Signature

_____ _____
Relationship Date

Patient Condition/Chief Complaint History

Reason for visit:_____ Date symptoms began:_____
How did your symptoms arise? ❑From lifting ❑From bending ❑Woke up with symptoms ❑While playing sports
❑Yard work ❑Gradually ❑Unknown ❑Other:_____
Is your condition getting progressively worse? ❑Y ❑N ❑Unknown
Please rate the severity of your pain on the scales below, 0 none, 10 severe:
Past 24 hours: 0 1 2 3 4 5 6 7 8 9 10 Past Week: 0 1 2 3 4 5 6 7 8 9 10
Please describe the type of pain you are experiencing (check all that apply):
❑Sharp ❑Dull ❑Throbbing ❑Aching ❑Shooting ❑Burning ❑Cramping
❑Numbness ❑Tingling ❑Stiffness ❑Swelling ❑Other:_____
How often do you experience your symptoms? ❑Constantly (75-100% of the day)
❑Frequently (50-75% of the day) ❑Intermittantly (25-50% of the day)
❑Occasionally (under 25% of the day) ❑Sporadically (not every day)
What activites aggrivate your symptoms? ❑Sitting ❑Standing ❑Walking
❑Bending ❑Lifting ❑Twisting ❑Lying down ❑Other:_____
What alleviates your symptoms? ❑Rest ❑Ice ❑Heat ❑Pain medication
❑Lying down ❑Activity ❑Nothing ❑Other:_____
Do your symptoms interfere with: ❑Work ❑Sleep ❑Daily routine ❑Recreation

Mark an **X** below where you feel pain and **//** for areas with numbness and/or tingling



Dr's initials indicate form was reviewed:_____

Patient Past Medical History

What treatment have you already received for your condition? ❑None ❑Medication ❑Surgery ❑Physical Therapy
❑Chiropractic ❑Accupunture ❑Other:_____

Name(s) and specialty of other doctors seen for your condition:_____

Have you had any similar symptoms or injuries to the area? ❑Yes ❑No Describe:_____

Date of last: Physical Exam _____ Spinal Exam _____ Blood Test_____ Urine Test_____

Spinal X-ray_____ Chest X-ray_____ Dental X-ray_____ MRI/CT/Bone Scan_____

Please mark if you currently have (C) of have had in the past (P) any of the following:

____AIDS/HIV	____Emphysema	____Measles	____Rheumatic Fever
____Alcoholism	____Epilepsy	____Migraine Headaches	____Scarlet Fever
____Allergy Shots	____Fractures	____Miscarriage	____Sinus Problems
____Anemia	____Glaucoma	____Mononucleosis	____Stroke
____Appendicitis	____Goiter	____Multiple Sclerosis	____Suicide Attempt
____Arthritis	____Gout	____Mumps	____Thyroid Problem
____Asthma	____Heart Disease	____Osteoporosis	____Tonsilitis
____Bleeding Disorders	____Hepatitis	____Pace Maker	____Tuberculosis
____Breast Lump	____Hernia	____Parkinson's Disease	____Tumors/Growths
____Bronchitis	____Herniated Disc	____Pinched Nerve	____Typhoid Fever
____Cancer	____High Blood Pressure	____Pneumonia	____Ulcers
____Chemical Dependancy	____High Cholesterol	____Prostate Problems	____Whooping Cough
____Chicken Pox	____Kidney Disease	____Prosthesis	Other:_____
____Diabetes	____Kidney Stones	____Psychiatric Care	_____
____Difficulty Urinating	____Liver Disease	____Rheumatoid Arthritis	_____

Are there any diseases/conditions that run in your family? ❑No ❑Yes :_____

Women: Are you pregnant? ❑N ❑Y # of weeks____ Due date:_____ 1st day of last menstrual period_____

Number of pregnancies_____ Number of Children_____

Exercise Regime	**Work/Daily Activity**	**Habits**	**List Hobbies/Sports**
❑None	❑Sitting ❑Standing	❑Smoking:Packs/day_____ ❑N/A	_____
❑Mild	❑Light Labor ❑Heavy Labor	❑Alcohol:Drinks/week_____ ❑N/A	_____
❑Moderate	❑Prolonged Driving	❑Caffiene:Drinks/wk_____ ❑N/A	_____
❑Heavy	❑Heavy Lifting ❑Walking	❑High Stress Level	_____
Freq:_____	Hours per week_____	Reason:_____	_____

Prior injuries and/or surgeries you have had: Description Date(approximate)

Falls: ❑None _____

Head Injuries: ❑None _____

Broken Bones: ❑None _____

Dislocations: ❑None _____

Motor Vehicle Accidents: ❑None _____

Surgeries: ❑None _____

Medications ❑None **Allergies** ❑None **Vitamins/Herbs/Minerals** ❑None

By signing below, I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform the office and/or doctor of any changes in my health

Patient Signature_____ Date_____

Parent/Guardian Signature if minor_____ Date_____

Doctor Signature_____ Date_____