BRADLEY CHIROPRACTIC CLINIC

Date:_____ **Email Address**:_____

1st **Name**:_____ **Middle Name**:_____

Last Name:_____ **Prefer to be called**:_____

Home Address:_____

City:_____ **State**:_____ **Zip Code**:_____

DOB:_____ **Age**:_____ **SS#**_____ **Circle One**: *Male Female*

Primary Phone #: (_____)_____ **Cell Phone**(_____)_____

Work Phone: (_____)_____ **Emergency Contact Name & #**:_____

Employer :_____ **Occupation**:_____

Circle One: *Child, Single, Married, Other* **Spouse name**:_____

Circle One: *FT Employed, PT Employed, Student, Self Employed, Retired, Disabled*

Race (Circle One):

White Black/African American Hispanic American Indian/Alaskan Native Asian Chinese
Filipino Japanese Korean Native Hawaiian/Pacific Island Vietnamese
Samoan Other:_____ I choose not to answer

Do you currently smoke any kind of tobacco? (Circle One): Yes Former Smoker Never Smoked
Level of interest in quitting on scale of **One** (Not interested) to **Ten** (Very Interested):_____

Current Medications	**Dosage**	**Frequency**
1)_____		
2)_____		
3)_____		
4)_____		
5)_____		

Allergic to any Medications? Yes No If yes, list them below:

Medication Allergy	**Reaction**	**Date Began**
1)		
2)		
3)		

List any serious health issues:_____

_____

List any surgeries, dates & doctor who did it:_____

List any past serious accidents/falls:_____

Circle Yes or No

Y N Heart Attack/Stroke	Y N Heart Surg/Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV/AIDS	Y N Shingles	Y N Cancer
Y N High/Low Blood Pressure	Y N Emphysema/Glaucoma	Y N Anemia
Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Kidney Problems
Y N Ulcers/Colitis	Y N Severe/ Frequent Headache	Y N Sinus Problems
Y N Asthma	Y N Fainting/Seizure/Epilepsy	Y N Difficulty Breathing
Y N Chemotherapy	Y N Artificial Bones/Joints	Y N Arthritis
Y N Diabetes	Y N Covid-19, Date_____	

Females: Are you pregnant?_____ How many weeks?_____ Nursing?_____

Name of Primary Doctor:_____

Circle One: *health insurance* *auto accident insurance* cash *other*

If you are filing health insurance, please present your card at the front desk. Co-pays are expected at the time of the visit.

For Auto Accidents:

Liability Insurance Co:_____ Claim #_____

Adjuster/Attorney Name:_____ Phone #_____

Med Pay Insurance Co:_____ Claim#_____

This visit is due to: Auto Accident_____ Work Related_____ Fall_____ Other_____

Auto Accident Questions, if apply: Driver or **Passenger**

Seatbelt On? Yes No **Airbags Deploy?** Yes No

Describe the pain and location:_____

_____

When did the condition begin?_____ **Date of the accident:**_____

Is the condition getting worse? Yes No

Is the pain: constant_____ does it come & go_____

Is the condition interfering with: Work_____ Sleep_____ Daily Routine:_____

Have you had a similar condition in the past? Yes No

Have you been treated by another doctor for this condition? Yes No

If so, Doctor's Name & Office:_____ Results:_____

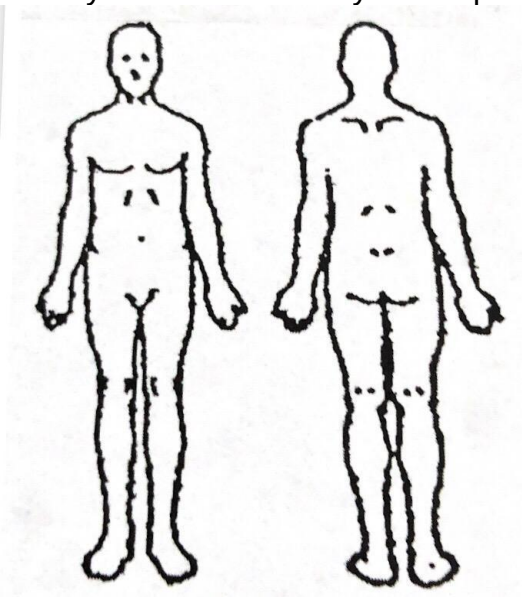
Have you missed any days from work due to this condition?_____

How many?_____

Have you had any x-rays taken for this condition?_____

Where?_____

Have you been treated by a chiropractor before? Yes No



Front Back

Mark on the picture where you have pain.