WELCOME

CHART #: ___________

DATE: ___________

BRANTLEY CHIROPRACTIC, P.C.
420 WEST AVENUE, NORTH AUGUSTA, SC 29841
O: 803-202-0202 F: 803-202-0201

MR. MRS. MS. DR. MISS

NAME: ____

DOB: ______________ SSN: ______ ____ ________

MARITAL STATUS: _________________

SEX: ____________ SEX AT BIRTH: ____________

ADDRESS: ____

CITY: _____________ STATE: _________ ZIPCODE: ____________

HOME PHONE: _____________

CELL PHONE: ________________ TEXT REMINDERS? YES NO

CELL PHONE COMPANY: ________________

EMAIL: ____

OCCUPATION: ______________________

HOW LONG? _______________________

EMPLOYER: ________________________

ADDRESS: _________________________

WORK PHONE: _____________________

PLEASE CIRCLE:

MEDICARE / MEDICARE ADVANTAGE / OTHER

IF OTHER:

INSURANCE PROVIDER: ______________

PREFERRED COMMUNICATION METHOD:

PHONE EMAIL

SPOUSE NAME: ___________________ DOB: _______

SPOUSE PHONE: ______________________________

SPOUSE EMPLOYER: ___________________________

EMERGENCY CONTACT INFORMATION:

NAME: ___________________________________

RELATIONSHIP: ____________________________

PHONE: __________________________________

DO YOU HAVE A PRIMARY CARE PHYSICIAN? YES NO

NAME (*FIRST AND LAST*): ____ PHONE: _____________________

ADDRESS: ____

WHOM MAY WE THANK FOR REFERRING YOU? ____

HAVE YOU BEEN A PATIENT OF BRANTLEY CHIROPRACTIC, P.C. IN THE PAST? YES NO

PREFERRED LANGUAGE: ______________________ RACE: ________________

ETHNICITY (circle): NOT HISPANIC OR LATINO / HISPANIC OR LATINO / OTHER / PREFER NOT TO ANSWER

ARE YOU CURRENTLY A SMOKER? YES NO If yes, how long? ____ past smoker? _____ Quit Date ______

You are fully responsible for all costs incurred at time of service. Per our insurance policy, our office only files Medicare. However, if you have insurance, we will be glad to provide you with instructions and the necessary information for you to file your insurance. We are a Non-Participating Provider (out-of-network) for all insurance companies. For your convenience, we gladly accept Discover, Mastercard, Visa, and American Express.

By signing below, I fully understand and agree to the terms. If under 18, a parent or guardian must sign.

_____________________________________ _________________________________ _______________

Responsible Party Signature **Relationship** **Date**

CHART #: ___________

Patient Name: ____________________________________ **DATE:** ___________

HAVE YOU BEEN DIAGNOSED WITH *ANY* MEDICAL CONDITIONS? YES NO

If yes, please circle:

Alcoholism	Anemia	Arthritis	Asthma
Autoimmune issues	Bleeding disorder	Bronchitis	Chemical dependency
Depression	Diabetes	Emphysema	Epilepsy
Hepatitis	Hernia	Herniated Disc	High Blood Pressure
High Cholesterol	HIV/AIDS	Kidney Disease	Migraine Headache
Multiple Sclerosis	Osteoporosis	Pacemaker	Parkinson's
Pneumonia	Polio	Prostate Problems	Rheumatoid Arthritis
Stroke	Thyroid Problems	Tumor/Cyst	

Cancer (list types/location/dates): ____

Other: ____

ARE YOU *CURRENTLY* TAKING ANY MEDICATIONS (including vitamins and organics)? YES NO

If yes, please list or provide a list:

1. ___________________ dosage ____ x per day ____ 4. __________________ dosage ____ x per day ____
2. ___________________ dosage ____ x per day ____ 5. __________________ dosage ____ x per day ____
3. ___________________ dosage ____ x per day ____ 6. __________________ dosage ____ x per day ____

HAVE YOU HAD SURGERY? YES NO

If yes, please list: ____

HAVE YOU HAD ANY ACCIDENTS/INJURIES/FALLS/BROKEN BONES? YES NO

If yes, please list: ____

DO YOU HAVE *ANY* ALLERGIES (medications, food, environmental)? YES NO

If yes, please list: ____

HAVE YOU HAD ANY CHANGE WITH BODILY FUNCTION? YES NO

If yes, please circle:

Change in vision	Difficulty swallowing	Difficulty breathing
Change in bowel movement	Incontinence	Motor weakness
Loss of balance	Dizziness	

HOW DO YOU USE YOUR SPARE TIME? ____

ARE YOU ON A SPECIAL DIET? YES NO If yes, please list: ______________________________

DO YOU HAVE A REGULAR EXERCISE PROGRAM? YES NO If yes, please list: ____________________

PLEASE LIST YOUR FAMILY MEDICAL HISTORY:

MOTHER ______________________________ FATHER ______________________________

BROTHER(S) ______________________________ SISTER(S) ______________________________

MATERNAL GRANDMOTHER/GRANDFATHER ____

PATERNAL GRANDMOTHER/GRANDFATHER ____

DATE OF LAST:

PHYSICAL EXAM ________ BONE DENSITY ________ BLOOD WORK ________ PSA TESTING (men prostate) ________

PHYSICAL EXAM ________ BONE DENSITY ________ BLOOD WORK ________ PSA TESTING (men prostate) ________

PHYSICAL EXAM ________ BONE DENSITY ________ BLOOD WORK ________ PSA TESTING (men prostate) ________

By signing below, I acknowledge this is my complete medical history. If under 18, a parent or guardian must sign.

______________________________ ______________________________ ______________

Responsible Party Signature **Relationship** **Date**

Please review the previous information to confirm it is correct and current. If there have been any changes, please inform the front desk staff to ensure the new information has been properly recorded for your patient chart. By signing below, you acknowledge your information has not changed since your last visit.

Date: ________ Signature ______________________ Date: ________ Signature ______________________

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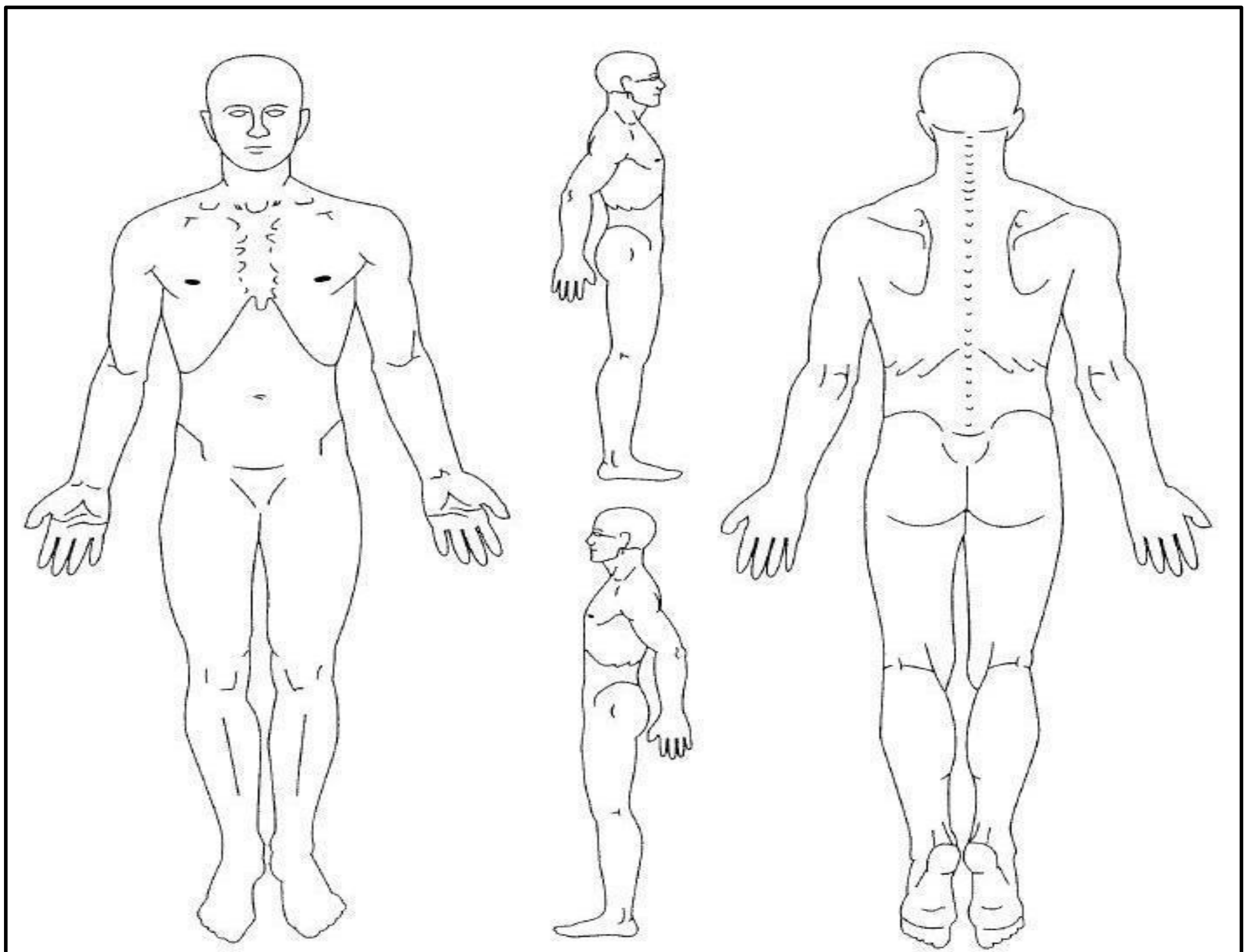
Disability Index Questionnaire

Name ____ **Date _____________________**

By using the key below, indicate on the body diagram where you are experiencing pain.

A = ACHING	**P = PINS & NEEDLES**	**N = NUMBNESS**
B = BURNING	**S = STABBING**	**O = OTHER**



________________________________ ________________________________ ______________

Responsible Party Signature **Relationship** **Date**

CHART #: ___________

Patient Name: ____ **DATE: ___________**

PLEASE COMPLETE EACH QUESTION, INDICATING N/A OR NONE, IF APPROPRIATE:

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? YES NO **If yes, date of last visit:** _____________

PRIMARY COMPLAINT: ________________________ **SINCE THIS ISSUE BEGAN, IT IS NOW:** SAME BETTER WORSE

DOES THE PAIN RADIATE TO ANY OTHER PARTS OF YOUR BODY? YES NO **IF YES, WHERE?** ____________________

ON A SCALE OF 1-10 (1 – LEAST SEVERE, 10 – MOST SEVERE), WHAT IS YOUR LEVEL OF DISCOMFORT?

1 2 3 4 5 6 7 8 9 10

FREQUENCY OF DISCOMFORT: CONTINUOUS FREQUENT OCCASIONAL INTERMITTENT

TYPE OF DISCOMFORT: CIRCLE ***ALL*** THAT APPLY

Aching	Dull	Sharp	Stiffness	Throbbing
Burning	Numbness	Shooting	Swelling	Tingling

IS THIS COMPLAINT WORSE AT A CERTAIN TIME OF THE DAY? YES NO **IF YES, WHEN?** ____________________

CIRCLE: *Gradual or Sudden?* **Date condition began:** _______________ **Cause:** ____________________

WHAT MAKES IT WORSE? _________________________ **WHAT MAKES IT BETTER?** ________________________

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? YES NO

IF YES, NAME OF DOCTOR/HEALTHCARE FACILITY? _____________________ **WHAT WAS TREATMENT?** ____________

2ND COMPLAINT: ___________________________ **SINCE THIS ISSUE BEGAN, IT IS NOW:** SAME BETTER WORSE

DOES THE PAIN RADIATE TO ANY OTHER PARTS OF YOUR BODY? YES NO **IF YES, WHERE?** ____________________

ON A SCALE OF 1-10 (1 – LEAST SEVERE, 10 – MOST SEVERE), WHAT IS YOUR LEVEL OF DISCOMFORT?

1 2 3 4 5 6 7 8 9 10

FREQUENCY OF DISCOMFORT: CONTINUOUS FREQUENT OCCASIONAL INTERMITTENT

TYPE OF DISCOMFORT: CIRCLE ***ALL*** THAT APPLY

Aching	Dull	Sharp	Stiffness	Throbbing
Burning	Numbness	Shooting	Swelling	Tingling

IS THIS COMPLAINT WORSE AT A CERTAIN TIME OF THE DAY? YES NO **IF YES, WHEN?** ____________________

CIRCLE: *Gradual or Sudden?* **Date condition began:** _______________ **Cause:** ____________________

WHAT MAKES IT WORSE? _________________________ **WHAT MAKES IT BETTER?** ________________________

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? YES NO

IF YES, NAME OF DOCTOR/HEALTHCARE FACILITY? _____________________ **WHAT WAS TREATMENT?** ____________

3RD COMPLAINT: ___________________________ **SINCE THIS ISSUE BEGAN, IT IS NOW:** SAME BETTER WORSE

DOES THE PAIN RADIATE TO ANY OTHER PARTS OF YOUR BODY? YES NO **IF YES, WHERE?** ____________________

ON A SCALE OF 1-10 (1 – LEAST SEVERE, 10 – MOST SEVERE), WHAT IS YOUR LEVEL OF DISCOMFORT?

1 2 3 4 5 6 7 8 9 10

FREQUENCY OF DISCOMFORT: CONTINUOUS FREQUENT OCCASIONAL INTERMITTENT

TYPE OF DISCOMFORT: CIRCLE ***ALL*** THAT APPLY

Aching	Dull	Sharp	Stiffness	Throbbing
Burning	Numbness	Shooting	Swelling	Tingling

IS THIS COMPLAINT WORSE AT A CERTAIN TIME OF THE DAY? YES NO **IF YES, WHEN?** ____________________

CIRCLE: *Gradual or Sudden?* **Date condition began:** _______________ **Cause:** ____________________

WHAT MAKES IT WORSE? _________________________ **WHAT MAKES IT BETTER?** ________________________

HAVE YOU BEEN TREATED BY ANOTHER DOCTOR FOR THIS CONDITION? YES NO

IF YES, NAME OF DOCTOR/HEALTHCARE FACILITY? _____________________ **WHAT WAS TREATMENT?** ____________

Please sign below. If under 18, a parent or guardian must sign.

_____________________________________ _________________________________ _______________

Responsible Party Signature **Relationship** **Date**