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 DOB: _____

NAME: _____

SSN: _____ ____ _____ MARITAL STATUS: _____

SEX: _____ SEX AT BIRTH: _____

ANY POSSIBILITY YOU ARE PREGNANT? YES NO

DATE OF LAST MENSTRUAL CYCLE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE: _____

HOME PHONE: _____ CELL PHONE: _____

CELL PHONE COMPANY: _____

TEXT REMINDERS? YES NO 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 ____
2. _____ dosage ____ x per day ____
3. _____ dosage ____ x per day ____
4. _____ dosage ____ x per day ____
5. _____ 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) _____

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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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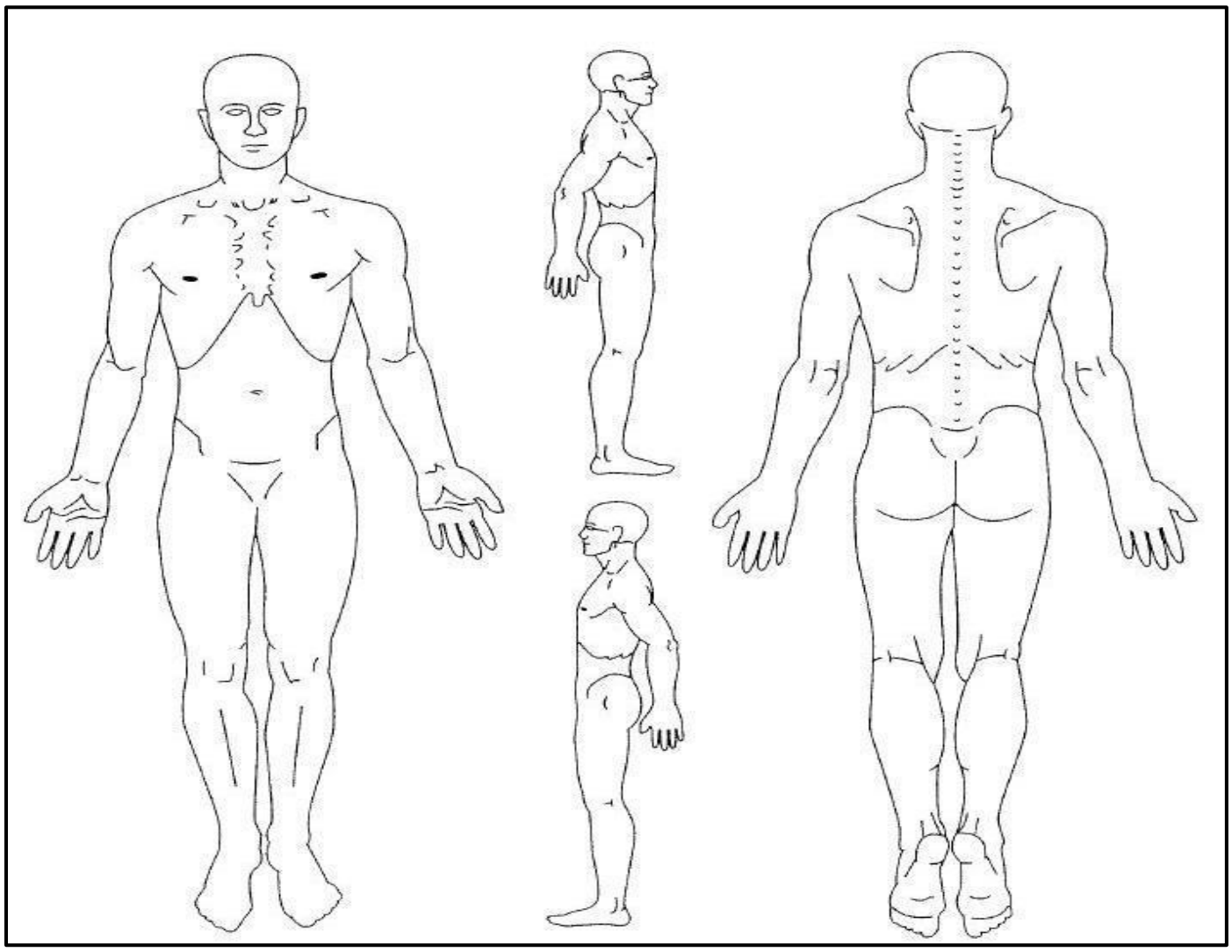
Disability Index Questionnaire

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**