Thank you for choosing Brantley Chiropractic for your chiropractic needs!

Addressing the needs of each patient is a personalized approach that is a priority in our practice. Attached are the new patient information sheets. We ask that you fill out in their entirety and bring them to your visit.

You will also need to download the following forms:

Oswestry

Financial Agreement

Privacy Disclosure

Headache disability (headaches only)

Please remember that you will be responsible for payment at the time of your visit.

We ask that you arrive 15 minutes prior to your scheduled appointment time. We take our appointments very seriously and are always thinking on how we can better serve our patients. If you must reschedule your appointment, we ask that you call us 24 hours in advance to avoid a $ 25.00 missed appointment fee. We value that time we’ve set aside for you.

If you have any questions or concerns prior to your appointment, please feel free to contact the office.

Welcome to Brantley Chiropractic

INSURANCE

PRIMARY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CIRCLE ONE: COMMERCIAL - MEDICARE OR MEDICARE ADVANTAGE

SECONDARY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

DO YOU HAVE A PRIMARY CARE PHYSICIAN? YES NO

NAME (*FIRST AND LAST*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT INFORMATION:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_

SPOUSE PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREFERRED COMMUNICATION METHOD:

PHONE EMAIL

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.**

**DATE OF LAST:**

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disability Index Questionnaire**

N**ame \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**A = ACHING**

**B = BURNING**

**P = PINS & NEEDLES**

**S = STABBING**

**N = NUMBNESS**

**O = OTHER**



**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

Burning

Dull

Numbness

Sharp

Shooting

Stiffness

Swelling

Throbbing

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

Burning

Dull

Numbness

Sharp

Shooting

Stiffness

Swelling

Throbbing

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

Burning

Dull

Numbness

Sharp

Shooting

Stiffness

Swelling

Throbbing

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**