WELCOME

Chart #: _____

Brantley Chiropractic, PC
420 WEST AVENUE, NORTH AUGUSTA, SC 29841
P: 803-202-0202 F: 803-202-0201

Date: _____

MR. MRS. MS. DR. MISS DOB: _____

NAME: _____

SSN: _____ ____ _____ MARITAL STATUS: _____

SEX: _____ SEX AT BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____ TEXT REMINDERS: YES NO

CELL PHONE PROVIDER: _____

EMAIL: _____

PREFERRED COMMUNICATION METHOD: PHONE EMAIL

OCCUPATION: _____

HOW LONG? _____

EMPLOYER: _____

ADDRESS: _____

WORK PHONE: _____

Insurance:

MEDICARE / MEDICARE ADVANTAGE / OTHER

IF OTHER: _____

Females Only:
Date of last menstrual cycle: _____

Possibility of pregnancy? YES NO

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: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

HAVE YOU BEEN A PATIENT OF BRANTLEY CHIROPRACTIC, PC IN THE PAST? YES NO

PREFERRED LANGUAGE: _____ RACE: _____

ETHNICITY: NOT HISPANIC OR LATINO / HISPANIC OR LATINO / OTHER / PREFER NOT TO ANSWER

ARE YOU A CURRENT SMOKER? YES NO If yes, how long? ____ Past Smoker? YES NO Quit Date: _____

You are fully responsible for all costs incurred at time of service. Our office is non-participating (out-of-network) with all insurance providers. Per our insurance policy, our office only files traditional Medicare. Upon request, we can provide documentation for you to file for reimbursement.

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**

Patient Name: _____ Chart #: _____

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 ANY SURGERIES? 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	

HAVE YOU SEEN A CHIROPRACTOR BEFORE? YES NO If yes, date of last treatment: _____

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 _____

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**

Patient Name: _____ Chart #: _____
Date: _____

Personal Injury Intake

Date of Accident: _____ Time: _____ AM PM Location: _____
Have you retained an attorney? YES NO If yes, who? _____

Describe how the accident occurred:_____

_____

_____

Were you the: DRIVER FRONT PASSENGER REAR PASSENGER (LT/RT/MIDDLE) Other: _____
What type of vehicle were you in? SMALL / MEDIUM / LARGE CAR / SUV / TRUCK Other: _____
What type was the other vehicle? SMALL / MEDIUM / LARGE CAR / SUV / TRUCK Other: _____

Impact to your vehicle: FRONT REAR LT SIDE RT SIDE Did your head hit the head rest? YES NO
Did you lose consciousness? YES NO Did any other part of your body contact interior of car? YES NO
If yes, describe: _____
What direction were you looking at time of impact? AHEAD TO LEFT TO RIGHT DOWN UNCERTAIN

Movement of your vehicle? STOPPED MOVING FORWARD BACKING UP TURNING LEFT / RIGHT
Movement of other vehicle? STOPPED MOVING FORWARD BACKING UP TURNING LEFT / RIGHT
Estimated speed of your vehicle: _____ MPH Estimated speed of other vehicle? _____ MPH
How much damage to your vehicle? HEAVY MODERATE SLIGHT NONE TOTALED UNKNOWN
How much damage to other vehicle? HEAVY MODERATE SLIGHT NONE TOATLED UNKNOWN
Was your vehicle towed? YES NO Were you wearing a seatbelt? YES NO Airbags deploy? YES NO
Were police on scene? YES NO Accident report completed? YES NO Citations issued? YES NO
If yes, to whom? _____ Was EMS on scene? YES NO
Have you had any treatment or imaging (x-rays, CT scans, MRI, etc.) since the accident? YES NO
If yes, describe:_____

Did you have any pain at time of accident? YES NO If yes, describe: _____
_____
Have you been able to work since this injury? YES NO Are your activities restricted as a result of this accident? YES NO If yes, describe: _____
Circle ***any*** symptoms you have noticed since the accident:

Headache	Sleeping Problems	Leg Pain
Neck Pain/Stiffness	Blurred Vision	Numb Feet/Toes
Dizziness	Ringing in Ears	Shortness of Breath
Upper Back Pain	Fatigue	Diarrhea
Nervousness	Jaw Pain/Problems	Constipation
Tension	Arm/Shoulder Pain	Other: _____
Irritability	Numbness Hands/Fingers	_____
Memory Loss	Low Back Pain	_____

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

Patient Name: _____ Chart #: _____

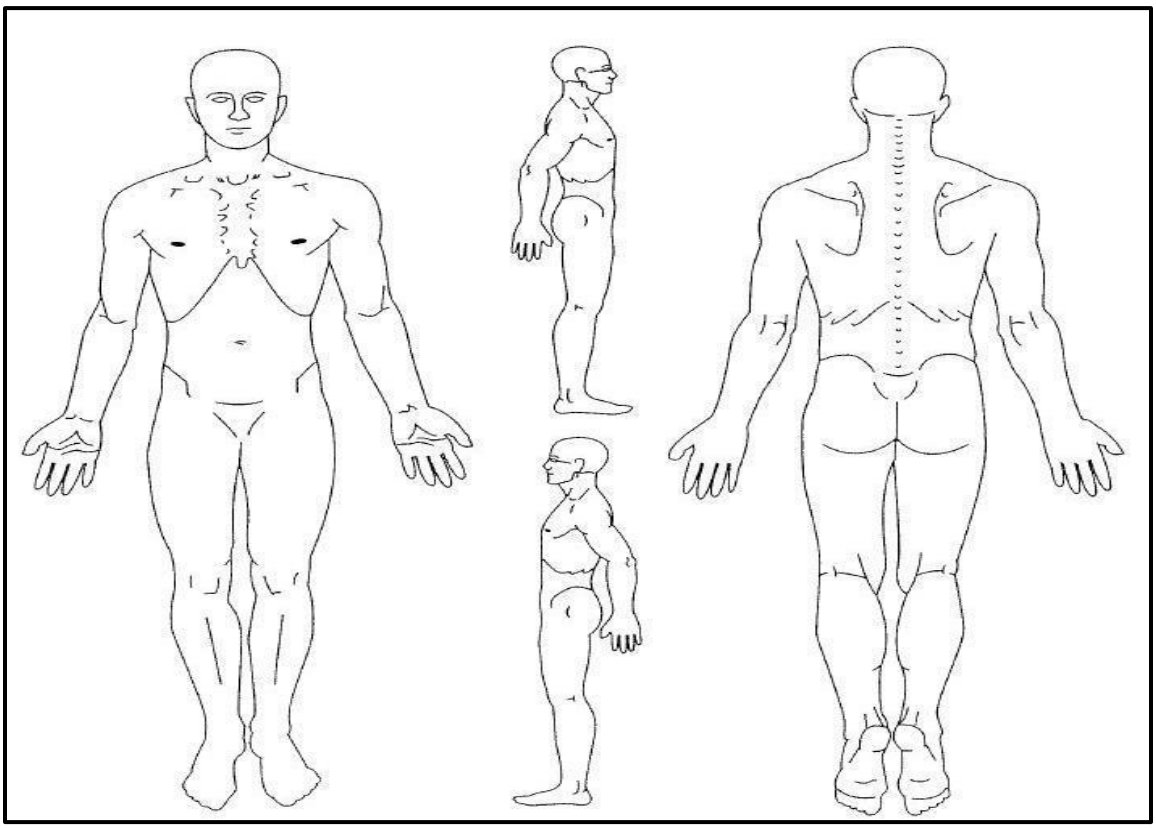
Date: _____

Personal Injury Intake

Using the key below, indicate on the body diagram where you are experiencing pain/discomfort:

A = ACHING P = PINS & NEEDLES N = NUMBNESS

B = BURNING S = STABBING O = OTHER



Please complete the following questions about your complaints in order of *most severe to least severe*:

Chief Complaint: _____ Does the pain radiate? YES NO If yes, where? _____

On a scale of 1-10, with 1 being the least severe and 10 being the most severe, what would you rate your discomfort?

1 2 3 4 6 7 8 9 10

Frequency of discomfort? Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (1-25%)

Type of Discomfort (Circle all that apply):

Aching Burning Dull Numbness Sharp Shooting Stiffness

Swelling Throbbing Tingling Cramping Deep Tightness Other

When is it at its worst? With Activity Morning On & Off Most of Day End of Day All Day Long Uncertain

Describe Onset: Gradual Sudden When did this begin? _____ Cause? _____

Since this began, it has been: The Same Better Worse What aggravates this complaint? _____

_____ What relieves this complaint? _____

Have you had any treatment for this condition? Yes No If yes, explain: _____

Patient Name: _____ Chart #: _____

Date: _____

Personal Injury Intake

2nd Complaint: _____ Does the pain radiate? YES NO If yes, where? _____

On a scale of 1-10, with 1 being the least severe and 10 being the most severe, what would you rate your discomfort?

1 2 3 4 6 7 8 9 10

Frequency of discomfort? Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (1-25%)

Type of Discomfort (Circle all that apply):

Aching Burning Dull Numbness Sharp Shooting Stiffness

Swelling Throbbing Tingling Cramping Deep Tightness Other

When is it at its worst? With Activity Morning On & Off Most of Day End of Day All Day Long Uncertain

Describe Onset: Gradual Sudden When did this begin? _____ Cause? _____

Since this began, it has been: The Same Better Worse What aggravates this complaint? _____

_____ What relieves this complaint? _____

Have you had any treatment for this condition? Yes No If yes, explain: _____

3rd Complaint: _____ Does the pain radiate? YES NO If yes, where? _____

On a scale of 1-10, with 1 being the least severe and 10 being the most severe, what would you rate your discomfort?

1 2 3 4 6 7 8 9 10

Frequency of discomfort? Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (1-25%)

Type of Discomfort (Circle all that apply):

Aching Burning Dull Numbness Sharp Shooting Stiffness

Swelling Throbbing Tingling Cramping Deep Tightness Other

When is it at its worst? With Activity Morning On & Off Most of Day End of Day All Day Long Uncertain

Describe Onset: Gradual Sudden When did this begin? _____ Cause? _____

Since this began, it has been: The Same Better Worse What aggravates this complaint? _____

_____ What relieves this complaint? _____

Have you had any treatment for this condition? Yes No If yes, explain: _____

4th Complaint: _____ Does the pain radiate? YES NO If yes, where? _____

On a scale of 1-10, with 1 being the least severe and 10 being the most severe, what would you rate your discomfort?

1 2 3 4 6 7 8 9 10

Frequency of discomfort? Constant (76-100%) Frequent (51-75%) Intermittent (26-50%) Occasional (1-25%)

Type of Discomfort (Circle all that apply):

Aching Burning Dull Numbness Sharp Shooting Stiffness

Swelling Throbbing Tingling Cramping Deep Tightness Other

When is it at its worst? With Activity Morning On & Off Most of Day End of Day All Day Long Uncertain

Describe Onset: Gradual Sudden When did this begin? _____ Cause? _____

Since this began, it has been: The Same Better Worse What aggravates this complaint? _____

_____ What relieves this complaint? _____

Have you had any treatment for this condition? Yes No If yes, explain: _____

Any additional information/concerns? _____

_____

_____ _____ _____

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