Print Form

BRADLEY CLINIC OF CHIROPRACTIC

Date: _____ Email Address _____

Name: (Last) _____ (First) _____ (M) _____

What you preferred to be called: _____ Male: ☐ Female: ☐

Address: _____

City,State,Zip _____

Phone (home): _____ (Cell): _____ (Pager): _____

Social Security #: _____ Date of Birth _____ Age: _____

Employer: _____ Work Number: _____

Work Address: _____ Occupation: _____

Status: _____ Spouse: _____ Spouse DOB: _____

Attornew/Adjuster: _____ Claim# _____ Phone: _____

Insurance information * Primary card holder name: _____

Please present your insurance card at the frone desk. Please inform the front desk if you have a second insurnace.
Co-pays are expected at the time of service

This visit is due to: _____ if other please specify: _____

Please describe the pain and it's location: _____

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

Is the condition getting worse? _____

Is this condition interfering with: ☐ Work ☐ Sleep ☐ Daily Routine

Have you had a similar condition in the past? _____

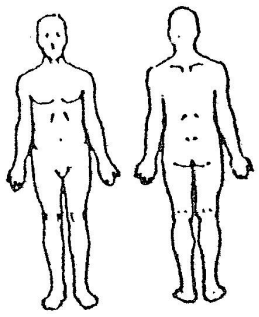
Have you been treated by a Medical Doctor for this condition? _____

If so, whom? _____ results: _____

Have you been treated by a chiropractor before? _____

Have you lost any days of work due to this condition? _____

If so, how many? _____ Have you returned to work? _____



*** Mark x on the Picture where you continue to have pain.**

HEALTH HISTORY

Are you taking any of the following medications?

☐ Nerve Pills ☐ Pain Killers (including asprin) ☐ Muscle Relaxers ☐ Stimulants

☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Others ☐ Vitamins

Name Medications: _____

Primary Care Physician: _____

Please check all that apply

☐ Heart Attack / Stroke	☐ Heart Surg / Pacemaker	☐ Heart Murmur
☐ Congenital Heart Defect	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Alcohol / Drug Abuse	☐ Venerial Disease	☐ Hepititis
☐ HIV / AIDS	☐ Shingles	☐ Cancer
☐ Frequent Back Pain	☐ Emphysema / Glaucoma	☐ Anemia
☐ High / Low Blood Pressure	☐ Psychiatric Problems	☐ Rheumatic Fever
☐ Severe / Frequent Headaches	☐ Kidney Problems	☐ Ulcer / Colitis
☐ Fainting / Seizure / Epilepsy	☐ Sinus Problems	☐ Asthma
☐ Diabetes / Tuberculosis	☐ Difficulty Breathing	☐ Chemotherapy
☐ Low Back Problems	☐ Artificial Bones / Joints	☐ Arthritis

Please list any other serious medical conditions you have or have ever had: _____

_____

List medical and or seasonal allergies: _____

List all surferies or treatments with dates: _____

_____

List any past serious accidents or falls with dates: _____

_____

Immediate Family Health History: _____

WOMEN: Are you Pregnant? _____ How many weeks? _____ Nursing? _____

Medical Authorization and Assignment of Payment

I hereby authorize the staff of The Bradley Chiropractic Clinic to release any information regarding services rendered by them and allow a photocopy of any signature to be used to file insurance. I also assign payment for benefits due me for the services rendered to be made directly to The Bradley Chiropractic Clinic regardless of my insurance benefits. I understand that I am financially responsible for the fees or services rendered. I understand that if I am accepted as a patient by the physicians of The Bradley Clinic, I authorize them to proceed with any treatment that may be necessary. Furthermore, any risk regarding chiropractic treatment will be explained to me upon treatment.

Patient's or Guardian's Signature: _____

☐ Adult Patient ☐ Parent / Guardian ☐ Spouse

Doctor's notes: _____

GENERAL PAIN DISABILITY INDEX QUESTIONAIRE

PATIENT NAME: _____ **DATE:** _____

The rating scales below are designed to measure the degree to which several aspect of your life is presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst. For each of the six categories of daily living listed, please circles the number which best describes your typical level of activities. *A score of 0 means no disruption in functioning at all, and a score of/U signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.*

PLEASE CIRCLE THE NUMBER WHICH BEST DESSRIBES YOUR TYPICAL LIMIT OF ACTIVITIES.

FAMILY / HOME RESPONSIBILITIES: this category refers to activities related to the home or family. It includes chores and duties performed around the house (e.g., driving the children to school).

0 1 2 3 4 5 6 7 8 9
Completely able to function totally unable to function

RECREATION: This category includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9
Completely able to function totally unable to function

SOCIAL ACTIVITY: This category refers to activities, which involve participation with friends and acquaintances other, that family members, it includes parties, theater, concerts, dining out, and other social functions.

0 1 2 3 4 5 6 7 8 9
Completely able to function totally unable to function

OCCUPATION: This category refers to activities that are part of our directly related to one's job. This includes non-paying jobs as well, such as that of a homemaker or volunteer worker.

0 1 2 3 4 5 6 7 8 9
Completely able to function totally unable to function

SELF CARE: This category includes activities, which involve personal maintenance and independent daily living (e. g., taking a shower, driving, getting dressed, etc.)

0 1 2 3 4 5 6 7 8 9
Completely able to function totally unable to function

LIFE-SUPPORT ACTIVITY: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

0 1 2 3 4 5 6 7 8 9
Completely able to function totally unable to function

SIGNATURE: _____ **DATE:** _____