Bryant Chiropractic Clinic

Patient Information

(Please Print in BLACK INK only) • (Please Do Not Leave Any Spaces Blank)

Date: ____/____/____

Personal Information

Name (F) ____ (M) ____ (L) ____

Mailing Address ____ City/State ____ Zip ____

Home Phone ____ Cell Phone ____ Text or Voice Reminder (CIRCLE ONE)

Birthdate ____ Age ____ Gender (circle one) M F Marital Status (circle one) S M W

SSN# ____ Your Email ____

Spouse's Name ____ Spouse's Contact Phone (for emergencies) ____

Spouse's Birthdate ____ Spouse's SSN# ____

Emergency Contact ____ Relationship ____

Your Employer ____ Work Phone ____ Occupation ____

How were you referred? (circle one) yellow pages, another patient, attorney, doctor, sign, other ____

Have you ever had chiropractic care? (circle one) Yes / No If Yes, when? ____

Have you had X-Rays, MRI, or CT Scan of your spine in the past two years? (circle one) Yes / No If yes, where? ____

General Physician ____ General Physician's Phone ____

I hereby authorize and direct you, Bryant Chiropractic Clinic, to release my examination notes to my general physician for his/her use only.

Signature ____

Your Symptoms

A. List your chief complaint(s) on each line (up to four) in order of severity: (examples: headaches, neck pain, back pain, arm pain, leg pain)

1. ____ When and Why did it start? ____
2. ____ When and Why did it start? ____
3. ____ When and Why did it start? ____
4. ____ When and Why did it start? ____

Comments ____

B. (Examples: ice, heat, Advil, Aleve, etc.) (Examples: sitting, bending, lifting, sleeping, turning, etc.)

1. What makes it better? ____ Worse? ____
2. What makes it better? ____ Worse? ____
3. What makes it better? ____ Worse? ____
4. What makes it better? ____ Worse? ____

Comments ____

C. (Circle One)

1. Is the pain? Constant Intermittent How long does it last? ____
2. Is the pain? Constant Intermittent How long does it last? ____
3. Is the pain? Constant Intermittent How long does it last? ____
4. Is the pain? Constant Intermittent How long does it last? ____

Comments ____

D.

1. Does the pain radiate down your arm or leg? (no, yes / explain) ____
2. Does the pain radiate down your arm or leg? (no, yes / explain) ____
3. Does the pain radiate down your arm or leg? (no, yes / explain) ____
4. Does the pain radiate down your arm or leg? (no, yes / explain) ____

Comments ____

E. (Please use a number from 0-10 or a combination of numbers, example: 1-5)

1. How severe is the pain? (0-no pain 10-severe pain) ____
2. How severe is the pain? (0-no pain 10-severe pain) ____
3. How severe is the pain? (0-no pain 10-severe pain) ____
4. How severe is the pain? (0-no pain 10-severe pain) ____

Comments ____

F. (Circle one)

1. Is the pain? Sharp Dull Other ____
2. Is the pain? Sharp Dull Other ____
3. Is the pain? Sharp Dull Other ____
4. Is the pain? Sharp Dull Other ____

Comments ____

G.

1. Have you ever had similar symptoms? (yes / no) ____
2. Have you ever had similar symptoms? (yes / no) ____
3. Have you ever had similar symptoms? (yes / no) ____
4. Have you ever had similar symptoms? (yes / no) ____

Comments ____

Mark your Area(s) of symptom(s)
Pain = X Numbness or Tingling = O

Front Back

PLEASE COMPLETE THE REVERSE SIDE

H. How has this condition(s) affected your:

1. Home Life
2. Occupational life?
   Duties Include: Sittings/hrs Standing/hrs Bending/hrs Lifting/hrs Working at a computer/hrs
3. Recreational life?
4. Rest and sleep life?

Medical History

Surgeries in the past five years:

Medication now taking: (include over the counter meds)

Cancer:

HIV positive? (circle one) Yes No If yes, how long?

Family history of (circle which applies) heart disease, diabetes, cancer, other:

Other concerns:

Work Accident - Are you being evaluated today for a work accident? ______Yes ______No (If yes, please fill out the following)

Date of Accident ______/______/______ Did you report this injury to your employer? Yes______ No______

Describe your accident

Employer Name Address

Manager's Name Phone

Workers Compensation carrier Phone

How many days of work have you lost/ (give dates)

Automobile Accident - Are you being evaluated today for an automobile accident? _____Yes _____No (If yes, please fill out the following)

Date of Accident ______/______/______ Were you issued a traffic citation? Yes______ No______ Police Report? Yes_____ No_____

Describe your accident in detail:

Your vehicle was a The other vehicle was a

How was your vehicle struck? (circle one) Front Rear R-side L-side R-Front corner L-Front corner R-Rear corner L-Rear corner

Your position in the car (circle one) Driver Passenger Front seat Rear seat Did you see the accident coming Yes______ No______

Were the brakes applied at the time of the accident (circle one) Yes No

Were you wearing your seat belt? (circle one) Yes No Did your airbag deploy? Yes No

How did you feel after the accident? Best describe discomfort during day?

Did you sustain any bruises or cuts? (explain)

Did you go to the hospital after the accident? Yes No How did you get there? (circle one) Ambulance Drove myself Someone drove me

Name of hospital

Treatment received since accident? Yes No Doctor"s name

Have you lost any days of work since accident? (give dates)

Do you have an attorney? Yes No Attorney's name

Attorney's Address

Insurance company responsibe

Your car insurance Med Pay Claim#

Adjuster's Name Adjuster's Phone #

Assignment, Lien, Authorization for Insurance Benefits, and Power of Attorney

I hereby authorize and direct you, my insurance company and/or my attorney to pay directly to Bryant Chiropractic Clinic, 1600 Sparkman Drive, Huntsville, AL 35816, such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness and by reason of any bills that are due this office and to withhold such sums from any disability benefits, workers compensation benefit, no-fault benefit, health and accident benefit or any other benefit obligated to reimburse me or from any settlement, judment, or verdict on my behalf as may be necessary to adequately protect said office. I understand that I remain personally responsible for the grand total amounts due to the office for services rendered. I understand that if I decide to change chiropractors before my personal injury case is settled I will be required to pay all sums due within seven working days from the day I change providers. I further understand and hereby grant to Bryant Chiropractic Clinic Power of Attorney for the sole purpose of endorsing on my behalf any negotiable instrument payable to this clinic for services rendered by them. I authorize Bryant Chiropractic Clinic to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this assignment, lien, and authorization.

I agree to pay for any attorney or collection agency fees incurred as a result of my failure to pay amounts due in a timely manner. If this account is turned over to an attorney for collection, I agree to pay all costs of collection including a reasonable attorney's fee for his reasonable percentage charged for the collection process. I hereby state that a photocopy of this document will be deemed as valid and binding on all parties as the original copy.

Patient Signature BCC Employee Signature Date ____/____/____

THANK YOU FOR YOUR REFERRALS