Bryant Chiropractic Clinic

Patient Information

(Please Print In BLACK INK)

Date___/___/___ (Please Do Not Leave Any Spaces Blank)

Personal Information

Name (F) ________________________________(M)______________________________(L)______________________________

Address____ City/State__________________________________ Zip___________

Home Phone__________________________ Cell Phone__________________________ Work Phone__________________________

Birth date__________________________ 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 Birth date ___________________________________ Spouse's SSN # ____

Emergency Contact (other than spouse)_____________________________Relationship_____________________Phone_____________

Your Employer _______________________________ Work Phone______________________ Occupation __________________

How were you referred to our office? (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) (up to four) in order of severity: (examples: Headaches, Neck pain, Back pain, Arm pain, Leg pain, etc.)

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 to 10 or a combination of numbers, example: 3-5)

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 ____________________________

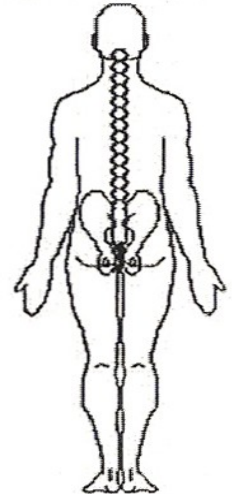
Comments____

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



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:________________________________
Medication now taking:________________________________
Cancer:________________________________
HIV positive? (circle one) Yes No If yes, how long? ________________________________
Pertinent family history________________________________
Other:________________________________

Work Accident

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

Date of accident_______/ _______/ _______ Were you issued a traffic citation? (circle one) Yes No
Describe your accident________________________________
____
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
Were your brakes applied at the time of the accident? (circle one) Yes No
Were you wearing your seat belt? (circle one) Yes No Were you knocked unconscious? Yes No
Did your seat break? (circle one) Yes No Did your airbag deploy? Yes No
Did you hit any object in the car?________________________________
Did you sustain any bruises or cuts? (explain)________________________________
Did you go to the hospital after the accident? Yes No How did you get there? 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________________________________ Phone________________________________
Insurance company responsible________________________________
Address________________________________ Phone________________________________
Your car insurance________________________________
Address________________________________ 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, judgment, 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 also 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 or 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.

Signature________________________________ **Witness**________________________________ **Date**______/ ______/ ______

THANK YOU FOR YOUR REFERRALS