WELCOME TO BRADY CHIROPRACTIC GROUP, PC

File # _____ Date _____

WELLNESS

Whom may we thank for referring you to us? _____

Name of primary physician _____ **Specialists** _____

Tobacco use: ☐ Never Smoked ☐ Former tobacco user ☐ Live with a smoker

☐ Current every day tobacco use ☐ Current occasional tobacco user

Alcohol consumption: ☐ None ☐ Rarely ☐ Social Drinker ☐ Recovering Alcoholic

Caffeine consumption: ☐ None ☐ Rarely ☐ Frequently -- ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks

HEALTH HISTORY

Cancer ☐ **Yes** ☐ **No** What kind? _____

High blood pressure	☐ **Yes** ☐ **No**	Mental Illness	☐ **Yes** ☐ **No**
Heart Disease	☐ **Yes** ☐ **No**	Losing weight now without trying	☐ **Yes** ☐ **No**
High cholesterol	☐ **Yes** ☐ **No**	Lost consciousness	☐ **Yes** ☐ **No**
Pacemaker	☐ **Yes** ☐ **No**	Loss of bladder or bowel control	☐ **Yes** ☐ **No**
Stroke	☐ **Yes** ☐ **No**	Noticing blood in stool or urine	☐ **Yes** ☐ **No**
Diabetes ☐ **Yes** ☐ **No** Type 1 (Insulin) Type 2		Coughing up blood	☐ **Yes** ☐ **No**
Osteoporosis	☐ **Yes** ☐ **No**	Recent episodes of weakness	☐ **Yes** ☐ **No**
Fibromyalgia	☐ **Yes** ☐ **No**	Recent double vision	☐ **Yes** ☐ **No**
Rheumatoid Arthritis	☐ **Yes** ☐ **No**	Recent dental work ☐ **Yes** ☐ **No** _____	
Thyroid disease	☐ **Yes** ☐ **No**	Joint replacements ☐ **Yes** ☐ **No** _____	
Implants of any kind	☐ **Yes** ☐ **No**	Surgeries ☐ **Yes** ☐ **No** _____	
Fractures ☐ **Yes** ☐ **No** _____		_____	

Other Medical or Health Concerns: _____

_____

Are you currently taking any medications? ☐ **Yes** ☐ **No** **If yes, please continue.**

Medications / prescribed and over the counter: Please allow us to make a copy of the list you carry with you.

_____ _____ _____

_____ _____ _____

_____ _____ _____

What vitamins or other nutritional supplements do you currently take?

_____ _____ _____

_____ _____ _____

Do you have any medication allergies? ☐ **Yes** ☐ **No** _____

FEMALES ONLY

Is there any chance that you are pregnant now? ☐ Yes ☐ No _____

Date of last menstrual cycle _____ How many children? ___ Vaginal birth ___ C-section ___

Pregnancy complications? ☐ Yes ☐ No _____

Have you had a bone density scan? ☐ Yes ☐ No Month _____ Year_____

FOR OFFICE USE

CURRENT CONCERNS

PRIMARY CONCERN: ◊ Neck pain ◊ Low back pain ◊ Back pain ◊ Headache ◊ Other

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WHAT CAUSED THE PAIN? ◊ Trauma ◊ Fall ◊ Unknown ◊ Other

WHEN DID THE PAIN START? _____ day(s) _____ week(s) _____ month(s) _____ year(s)

WHAT HELPS THE PAIN? Mark all that apply.

◊ ice ◊ heat ◊ stretching ◊ massage ◊ medication ◊ nothing ◊ other _____

WHAT AGGRAVATES THE PAIN? Mark all that apply.

◊ movement ◊ sitting ◊ standing ◊ walking ◊ driving ◊ lifting ◊ sleeping ◊ other _____

HOW WOULD YOU DESCRIBE THE PAIN? Mark all that apply.

◊ dull ◊ sharp ◊ tingling ◊ burning ◊ stabbing ◊ throbbing ◊ squeezing ◊ Other _____

WHERE DOES THE PAIN RADIATE? Mark all that apply.

◊ N/A ◊ R arm ◊ L arm ◊ R leg ◊ L leg ◊ R buttocks ◊ L Buttocks ◊ R hand/fingers ◊ L hand/ fingers

HOW SEVERE IS THE PAIN? 0 1 2 3 4 5 6 7 8 9 10

No Pain Severe Pain

HOW OFTEN DO YOU FEEL THE PAIN? ◊ Constant ◊ daily ◊ weekly ◊ monthly ◊ other _____

HAS THE PAIN IMPROVED SINCE IT STARTED? ◊ YES ◊ NO ◊ other _____

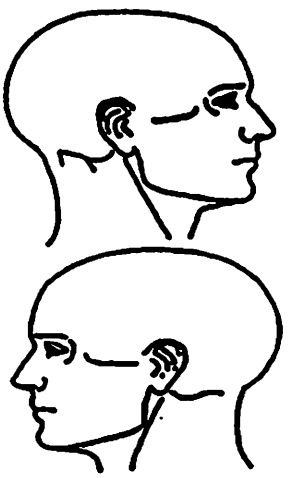
HAS THE PAIN WORSENED SINCE IT STARTED? ◊ YES ◊ NO ◊ other _____

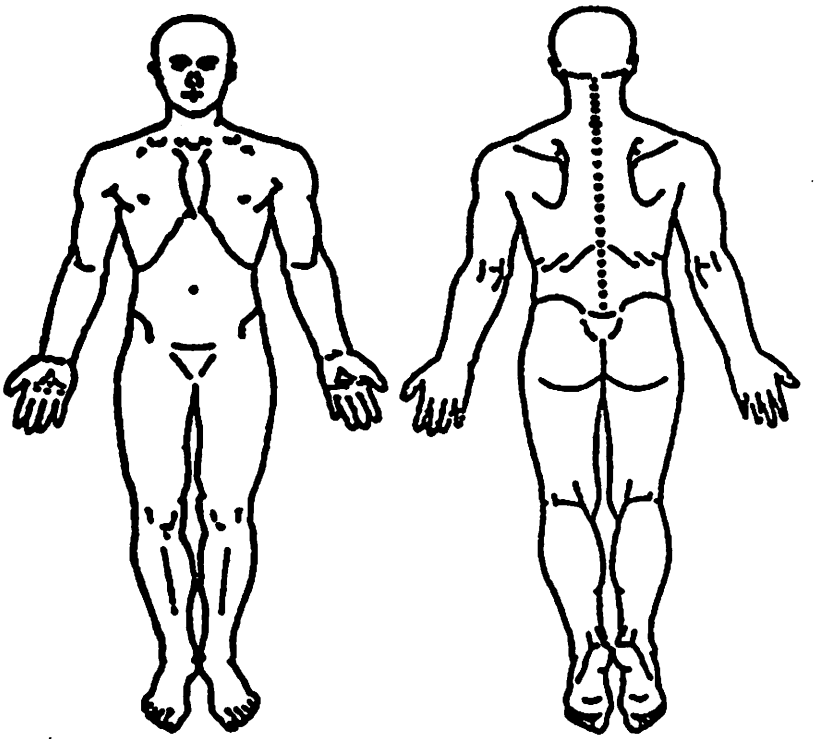
HAVE YOU HAD THIS TYPE OF PAIN BEFORE? ◊ YES ◊ NO ◊ other _____

HAVE YOU BEEN TREATED FOR THIS TYPE OF PAIN BEFORE? ◊ YES ◊ NO ◊ other _____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR?

Circle your areas of concern or the areas you would like to see improvement.





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