Brady Chiropractic

2929 Custer Rd, Suite 320 * Plano, Texas 75075

Phone: (972) 867-8500 * Fax: (972) 867-8509

Patient File #:

PATIENT INFORMATION: PLEASE PRINT

Today's Date: _____/_____/_____ Sex: Male/ Female

Name: _____
First MI Last

Name you prefer to be called: _____

Date of birth: _____/_____/_____ SS#_____

Home Address: _____

_____
City State Zip

Email: _____

Cell Phone #: _____

Consent to receive voicemails to schedule appointments: Yes / No

Employer: _____

Occupation: _____For how long?_____

Work Phone #: _____

How did you hear about us: _____

Marital Status: _____

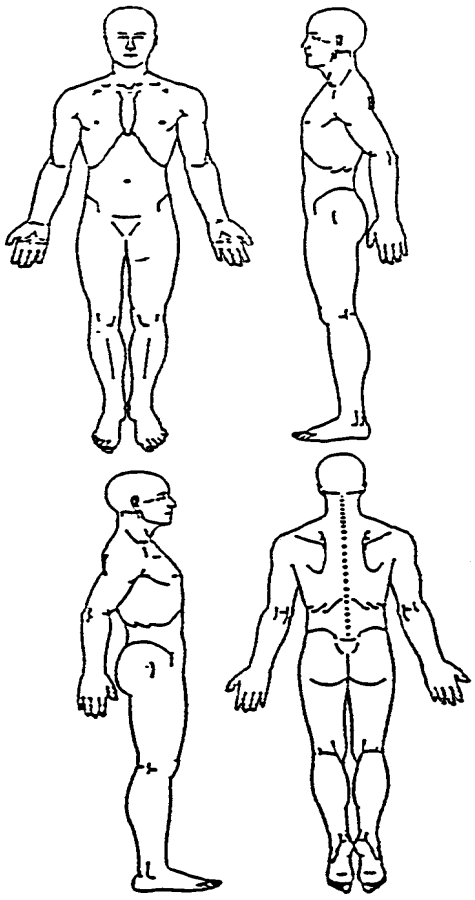
I give consent to leave messages regarding my appointments with the following individual (optional):

Name: _____ Relationship:_____

SYMPTOMS

Place an "X" on the drawing below on areas causing you pain and a letter to describe it:

A= ACHE
B= BURNING
S=STABBING
N=NUMBNESS
P= PINS/NEEDLES



EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone #: _____

Alternate Phone #: _____

ACCIDENT INFORMATION

Is the reason for today's visit due to an accident: Yes/No

Accident Date ___/____/____ Type: Auto/Work/Home/Other

I have opened a claim with: Auto Insurance/Worker's Comp/Other

Name of attorney (if applicable): _____

PATIENT CONDITION

Reason for today's visit: _____

When did symptoms begin: _____ Is this condition getting worse: Yes/ No/ Constant/ Comes & Goes

Condition interferes with (circle all that apply): Work/ Sleep/ Daily Routine Explain: _____

Symptoms change with the time of day: Yes/ No If yes, when are symptoms best: _____ worst: _____

Activities or movements that are painful to perform: Sitting/ Standing/ Walking/ Bending/ Lying Down/ Other: _____

Have you had this or similar conditions in the past: Yes/ No Explain: _____

What treatment have you received for this condition: Chiropractic/ Medication/ Injections/ Physical therapy/ Surgery/ Other:_____

PERSONAL HEALTH HISTORY: Please indicate if you have had any of the following

AIDS/HIV		Cataracts		Hepatitis		Parkinson's disease	
Alcoholism		Chicken pox		Herpes		Polio	
Allergy Shots		Diabetes		High cholesterol		Rheumatoid arthritis	
Anemia		Emphysema		Kidney disease		Scarlet fever	
Appendicitis		Glaucoma		Liver disease		Stroke	
Arthritis		Goiters		Measles		Thyroid problems	
Bleeding disorders		Gout		Migraines		Polio	
Cancer		Heart disease		Osteoporosis		Venereal disease	

FAMILY HISTORY

Please indicate whether you have a family history of the following:
F=Father, M=Mother, S=Sibling

Diabetes	F	M	S
Heart disease	F	M	S
Kidney disease	F	M	S
Cancer	F	M	S
Back problems	F	M	S

SYMPTOMS: Please indicate if you have had or are currently experiencing any of the following

GENERAL SYMPTOMS:
- ❑ Headaches
- ❑ Fever
- ❑ Night Sweats
- ❑ Dizziness
- ❑ Loss of Sleep
- ❑ Fatigue
- ❑ Weight Loss
- ❑ Numbness
- ❑ Neuralgia

RESPIRATORY:
- ❑ Chronic cough
- ❑ Chest Pain
- ❑ Difficulty breathing

EARS/EYES/NOSE/THROAT:
- ❑ Failing vision
- ❑ Deafness
- ❑ Earache
- ❑ Nose bleeds
- ❑ Sore throat
- ❑ Asthma
- ❑ Enlarged thyroid
- ❑ Sinus infection
- ❑ Enlarged glands

CARDIOVASCULAR:
- ❑ Rapid heartbeat
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Swollen ankles
- ❑ Poor circulation

MUSCLE & JOINT:
- ❑ Swollen joints
- ❑ Tremors
- ❑ Pain between shoulders
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture

GENITOURINARY:
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Prostate trouble

SKIN:
- ❑ Bruises easily
- ❑ Hives

GASTROINTESTINAL:
- ❑ Loss of appetite
- ❑ Poor digestion
- ❑ Nausea
- ❑ Vomiting
- ❑ Stomach pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Jaundice

WOMEN ONLY:
- ❑ Lumps in breast
- ❑ Previous miscarriage
- ❑ Currently pregnant

Medications: _____

Vitamins/Herbs/ Minerals: _____

Allergies: _____

	Description	Date
Falls/Accidents/Head injuries		
Broken bones/fractures/dislocations		
Surgeries		

Exercise:	Work Activity:	Habits:
None/ Moderate/ Daily / Heavy	Sitting/ Standing/ Light Labor/ Heavy Labor	Smoking/ Alcohol/ Caffeine/ High Stress

I authorize the staff to perform any necessary service needed during diagnosis and treatment. I guarantee this form was completed accurately to the best of my knowledge. I acknowledge it is my responsibility to inform the staff and this office of any changes in my medical status.

Print Patient Name: _____

Signature: _____ Date: _____

IF PATIENT IS A MINOR: Permission is herby given by me, the legal guardian, to the doctor(s) of this office and to whomever they designate to treat the patient.

Parent's signature: _____ Date: _____

BRADY CHIROPRACTIC
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QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

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ASSIGNMENT OF BENEFITS

PATIENT INFORMATION

First Name: _____ Last Name: _____

D.O.B. _____/_____/_____ Sex: M / F Primary Care Physician: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's D.O.B. _____/_____/_____

Policy Holder's Address: _____

City State Zip

Relationship to Policy Holder (please circle): Self Spouse Child Other

Secondary Insurance: _____ ID: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's D.O.B. _____/_____/_____

Relationship to Policy Holder (please circle): Self Spouse Child Other

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

BRADY CHIROPRACTIC IS AUTHORIZED TO OBTAIN INSURANCE INFORMATION FROM MY CARRIER(S) NECESSARY TO PROCESS CLAIMS FOR SERVICES RENDERED. BRADY CHIROPRACTIC IS AUTHORIZED TO RELEASE INFORMATION PERTAINING TO MY CONDITION/TREATMENT TO ANY INSURANCE COMPANY (OR ITS ADMINISTRATOR), ATTORNEY, OR ADJUSTER IN ORDER TO PROCESS INSURANCE CLAIMS GENERATED IN THE COURSE OF TREATMENT.

IN CONSIDERATION OF SERVICES RENDERED, I HEREBY IRREVOCABLY ASSIGN AND TRANSFER TO BRADY CHIROPRACTIC ALL RIGHTS, TITLE, AND INTEREST IN THE BENEFITS PAYABLE FOR SERVICES RENDERED BY DR. ROBERT BRADY PROVIDED IN THE ABOVE-MENTIONED POLICY OF INSURANCE. THERE IS NO OBLIGATION FOR BRADY CHIROPRACTIC TO PURSUE ANY SUCH RIGHT OF RECOVERY. I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER(S) INCLUDING PRIVATE INSURANCE, AUTO ACCIDENTS, ANY OTHER HEALTH/MEDICAL PLAN, AND/OR MY ATTORNEY OUT OF THE PROCEEDS OF ANY SETTLEMENT OF MY CASE, TO ISSUE PAYMENT/CHECK(S) DIRECTLY TO BRADY CHIROPRACTIC FOR MEDICAL SERVICES RENDERED.

OFFICE PAYMENT POLICY

MY COVERAGE WILL BE VERIFIED BY THIS OFFICE AS A COURTESY TO ME. THE COVERAGE AND BENEFIT INFORMATION, AS QUOTED BY MY INSURANCE CARRIER TO BRADY CHIROPRACTIC, MAY NOT BE ACCURATE. I SHOULD CONSULT MY PLAN DOCUMENTATION TO VERIFY COVERAGE AND BENEFITS INCLUDING COPAYS/COINSURANCE, DEDUCTIBLES, REFERRALS, AND EXCLUSIONS AND LIMITATIONS.

I AGREE TO PAY MY ESTIMATED PATIENT RESPONSIBILITY INCLCUDING COPAY/CO-INSURANCE AND APPICABLE DEDUCTIBLE AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THE ESTIMATED RESPONSIBILITY IS NOT A GUARANTEE OF PAYMENT BY MY INSURANCE COMPANY. A FINAL DETERMINATION IS MADE BY MY INSURANCE COMPANY DURING CLAIMS PROCESSING.

I HAVE READ AND UNDERSTAND THIS DOCUMENT. I AGREE TO ABIDE BY ITS CONTENTS. I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AS OF THE DATE SET FORTH BELOW AND I AM RESPONSIBLE FOR UPDATING IT. I CAN REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME. A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____

PATIENT SIGNATURE (OR GUARDIAN IF PATIENT IS A MINOR) DATE

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Informed Consent to Chiropractic Treatment

It is possible that a patient may notice temporary soreness, bruising, increased symptoms, or pain post treatment, particularly at the start of care.

As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include muscle strain, ligament sprain, joint dislocation, or bone fracture. Notify the office if you have been diagnosed with a bone weakening disease or condition.

Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Although extremely rare, studies have established an association between neck manipulation and a certain type of stroke. The evidence does not, however, prove that the practice of neck manipulations can directly cause strokes.

Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. No scientific study has demonstrated that such injuries are caused by adjustment or manipulative techniques.

Consent: I understand that the practice of chiropractic, like the practice of medicine, is not an exact science and no guarantee can be given as to the results or outcome of my care. I do not expect the doctor to be able to anticipate all risks/complications and wish to rely on the doctor to exercise judgement during the course of treatment based on the facts then known to him/her. I have evaluated the risks and benefits of undergoing treatment and consent to undergo recommended treatment for myself or the patient below for whom I am legally responsible. I intend this consent to cover the course of treatment for my current condition and future condition(s) for which I seek care at Brady Chiropractic.

_____	_____	_____
Print Patient Name	**Patient Signature (Parent/Guardian Signature if Minor)**	**Date**

Brady Chiropractic

Notice of Privacy Practices (HIPAA)

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. Questions about this notice can be addressed to: 2929 Custer Rd, Suite 320, Plano, TX 75075, ATTN: Facility Privacy Official.

We may use and disclose your health information to other healthcare providers/professionals in order to provide treatment or services, bill and collect payment from you, your insurance company, a third-party payer, or a friend or family member who is involved in or who helps pay for your care. We may disclose health information to business associates we have contracted with to perform the agreed upon service and billing for it, to remind you of appointments, to assess your satisfaction with our services, to tell you about treatment alternatives, in billing/collections efforts, and we may leave messages on your answering machine or voicemail about these items and services. We may communicate to you via newsletters, telephone, email, text, or other means regarding health-related information, appointments, reminder notices, or other activities we deem appropriate. We may disclose health information for law enforcement purposes as required by law or in response to a subpoena, Food & Drug Administration, Public Health or Legal Authorities, charged with preventing or controlling disease, injury or disability, Correctional Institutions, Workers Compensation Agents, National Security and Intelligence Agencies, or others. You have the right to inspect and obtain a copy of your health information and billing records. You may request that our office amend the information in your records if you feel it is incorrect or incomplete. You have the right to a paper copy of this notice.

You may request that we communicate with you in a certain way or manner. These requests are required to be in writing. We reserve the right to contact you by other means if you fail to respond to any communication from us that requires a response.

By signing this form, I acknowledge I have reviewed the Patient Privacy Notice and understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES/ NO

May we leave a detailed message on your answering machine at home or on your cell phone? YES/ NO

May we discuss your medical condition with a family member or other designated representative? YES/ NO

If YES, please print their name(s):_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____