NEUROCARE MEDICAL GROUP, S.C.

D/B/A Bradley Chiropractic Clinic
2306 W. Main Street - Marion, IL 62959
Phone: (618) 997-5959 Fax: (618) 993-3161

CONFIDENTIAL PATIENT FILE INFORMATION

Patient # _____ Date _____

Last Name _____ First _____ Middle Initial _____ SS # _____

Address _____ City _____ State _____ Zip _____

Phone (H) _____ (C) _____ Email _____ Birthdate _____

Sex M or F Marital Status _____ Number of Children _____ Referred By _____

Employer _____ Occupation _____

Work Phone _____ Driver License # _____

Name of Spouse _____ SS # _____

Employer _____ Occupation _____

Name of Nearest Relative _____ Phone _____

Briefly describe Present Complaint _____

_____

List other Doctors seen for this condition _____

About Your Lifestyle:

Exercise:
☐ None ☐ Daily
☐ Moderate ☐ Heavy

Work Activity:
☐ Sitting ☐ Light Labor
☐ Standing ☐ Heavy Labor

Lifestyle:
☐ Tobacco ☐ caffeine/coffee/tea
☐ Alcohol ☐ High Stress

Medical History (Please check if relevant to you)

____ Cancer
____ Polio
____ Tubuerculosis
____ High Blood Pressure
____ Heart Trouble
____ Diabetes
____ Hepatitis
____ German Measles
____ Venereal Disease
____ Muscular Dystrophy
____ Multiple Sclerosis
____ Convulsions
____ Epilepsy
____ Concussion
____ Dizziness
____ Arthritis
____ Neuritis
____ Rheumatism
____ Rheumatic Fever
____ Scarlet Fever
____ Nervousness
____ Asthma
____ Digestive Disorder
____ Sinus Trouble
____ Backaches
____ Numbness
____ Anemia
____ Pneumonia
____ Mumps
____ Influenza
____ Pleurisy
____ Whooping Cough
____ Eczema
____ Mental Disorder

Other Current Symptoms:

____ Headaches
____ Neck Pain
____ Loss of Balance
____ Back Pain
____ Nervousness
____ Tension
____ Irritability
____ Chest Pains
____ Dizziness
____ Face Flushed
____ Neck Stiff
____ Pins & Needles in Legs
____ Pins & Needles in Arms
____ Numbness in Fingers
____ Numbness in Toes
____ Shortness of Breath
____ Fatigue
____ Depression
____ Light Bothers Eyes
____ Loss of Memory
____ Ears Ring
____ Fever
____ Fainting
____ Cold Sweats
____ Loss of Smell
____ Loss of Taste
____ Diarrhea
____ Feet Cold
____ Hands Cold
____ Stomach Upset
____ Constipation

Describe any previous surgeries and when _____

_____

Have you been treated by a physician/chiropractor for any health conditions in the last year? ___ Yes ___ No

Describe _____

Are you currently taking any medication? ___ Yes ___ No What kind? _____

Are you allergic to any medication? ___ Yes ___ No What Kind? _____

Date of last Physical _____ Are you pregnant? _____ Yes _____ No

CHECK HERE IF YOU DO NOT WANT MESSAGES LEFT FOR YOU OR EMAILS ☐

What date did your current symptoms begin? _____

What best describes your current condition? ? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Achy ☐ Shooting ☐ Burning ☐ Stiff ☐ Tingling ☐ Constant ☐ On and Off

Does your pain radiate? ☐ Yes ☐ No If yes, Where? _____

Is the current condition interfering with work? _____ Sleep? _____

Is your condition worse during ☐ morning ☐ afternoon ☐ evening ☐ N/A

Is this condition getting progressively worse? _____

Rate your pain using the pain scale of 0 = no pain; 10=Worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

What treatment have you already received for your present condition? ☐ Prescription Medication ☐ Surgery

☐ Physical Therapy ☐ OTC Medication ☐ Ice Pack ☐ Heat Packs ☐ None ☐ Other _____

Have you been tested HIV positive? ☐ Yes ☐ No

Major Surgery/Operations: _____

Insurance Data (clinic policy requires payment arrangements be made on first visit)

Name of Party Responsible for Payment _____ Phone _____

Do you have insurance ____ Yes ____ No Company _____

Patient's Insurance _____ Employer I.D. # _____

Spouse's Insurance _____ Policy # _____

Worker's Compensation _____ Group # _____

Others _____ Medicare # _____

I understand and agree that health and accident insurance polices are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any less for professional services rendered me will be immediately due and payable.

SIGNATURE _____ DATE _____

SPOUSE'S OR
GUARDIAN'S SIGNATURE _____ DATE _____