Good News Chiropractic P.C., Jack Bradley D. C., Date _______/______/ 2022

101 N. Uncompahgre Ste 1 - Montrose Co.81401 (970) 252-8255

NEW PATIENT INFORMATION

Name ____________________________________
Home Address ____________________________
City ____________________________________
State ______________ Zip _______________
Home Phone (_____)___________________
Cell Phone (_____)___________________
Date of Birth ___________________________

Employer ____________________________________
Employer Address __________________________
Work Phone (_____) _______________________
Employed: Full-time __________
Part-time __________
Student: Full-time ____________
Non-student _________

Social Security No. _____________________
Date of first symptom ___________________

Single _____________ Married _____________
Divorced ___________ Widowed ____________

SPOUSE/PARENT INFORMATION

Spouse _____ Parent ______
Name ____________________________________
Home Address ____________________________
City ____________________________________
State ______________ Zip _______________
Date of Birth ___________________________

Employer ______________________________
Employer Address ________________________
Work Phone (_____) ______________________
Home Phone (_____)______________________
Social Security No. ______________________

Person Financially Responsible for this Account ____

INSURANCE INFORMATION

Your Insurance:
Company _____________________________________
Address ______________________________________
City ______________ State ___ Zip _____________
Claims Office Phone __________________________
Group No. _________________________________
Certificate/ID No. ____________________________

Secondary or Spouse/Parent Insurance:
Company ________________________________
Address _________________________________
City ______________ State ___ Zip _________
Claims Office Phone ______________________
Group No. _______________________________
Certificate/ID No. ________________________

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name _____________________________________
Home Phone (_____) _________________________
REFERRED BY: _____________________________

Relationship ______________________________
Work Phone (_____) ______________________

I understand and agree that health and accident insurance polices are an arrangement between the carrier and me. Furthermore, I understand that Good News Chiropractic will prepare any necessary receipts to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Bradley will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. (Medicare will be billed for spinal adjustments we believe they might pay for). I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

It is understood and agreed that any X-rays ordered by Dr. Bradley will remain the property of this Clinic, being on file where they may be seen at any time while a patient of this Clinic. The Clinic/Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

DATE ______________ Signature (Or Parent or Guardian) ______________________________________

Note: if you are a Medicare patient we need your Social Security Number to bill Medicare-- SS# ____________________________

We accept only Cash or Check in payment for services.

CHIEF COMPLAINT WORKSHEET

PATIENT NAME: ________________________________ D.O.B. ________ AGE: ______ DATE: ______________

INSTRUCTIONS: Circle all words in **Bold** letters that apply to your condition.

CHIEF COMPLAINT/PATIENT'S DESCRIPTION OF THE CHIEF PROBLEM AND OTHER CURRENT PROBLEMS:____

____

1. Describe exact location of pain/problem? ____

____

2. (Circle the symptom below and draw a line to the body parts involved) Rate your symptoms by placing an X on the lines below for each body part involved between none and the worst.

Right Left

Left Right

Ache
Burning
Cramping
Dull Pain
Intense Pain
Numbness
Goes to Sleep
Pin/Needles
Radiating
Sharp Pain
Soreness
Stiffness
Throbbing
Tender
Tight
Tingling
Weakness

	(0) Mild			Moderate				Severe			CONSTANT	FREQUENT	Intermittent
Head	1	2	3	4	5	6	7	8	9	10			
Neck	1	2	3	4	5	6	7	8	9	10			
Shoulders	1	2	3	4	5	6	7	8	9	10			
Arms	1	2	3	4	5	6	7	8	9	10			
Elbows	1	2	3	4	5	6	7	8	9	10			
Forearm	1	2	3	4	5	6	7	8	9	10			
Hands	1	2	3	4	5	6	7	8	9	10			
Fingers	1	2	3	4	5	6	7	8	9	10			
Ribs	1	2	3	4	5	6	7	8	9	10			
Thoracics	1	2	3	4	5	6	7	8	9	10			
Lumbar	1	2	3	4	5	6	7	8	9	10			
Sacrum	1	2	3	4	5	6	7	8	9	10			
S.I.	1	2	3	4	5	6	7	8	9	10			
Glutes	1	2	3	4	5	6	7	8	9	10			
Trochanter	1	2	3	4	5	6	7	8	9	10			
Groin	1	2	3	4	5	6	7	8	9	10			
Thigh	1	2	3	4	5	6	7	8	9	10			
Lower Leg	1	2	3	4	5	6	7	8	9	10			
Knee	1	2	3	4	5	6	7	8	9	10			
Foot	1	2	3	4	5	6	7	8	9	10			

3. WHEN DID YOUR CONDITION(S) START? _______/_______/_________ ______________________________

_______/_______/_________ ____

_______/_______/_________ ____

4. Did anything cause or contribute to the onset? **YES** or NO. If **Yes**, describe: ______________________________

____

IS IT CONSTANT OR INTERMITTENT? If intermittent how often?

____

5. Have you ever had anything like this before? Describe:______________________________________

6. Has your condition been getting better or worse? ____________ Same since ________________

Patient Name____

Please **(Circle)** the words in **Bold** that apply to your condition. Put any extra information in the blank spaces provided.

7. RELIEVING FACTORS :**walking, sitting, standing, lying down, adjusted, decompressed, or with manual therapy, ice, heat, or in certain positions**____

8. AGGRAVATING FACTORS -- **mornings, evenings, after work, walking, sitting, standing, standing up from a chair or bed, bending, lifting, twisting, turning my head (R) or (L), reaching above my head, coughing, sneezing, also in certain positions ----**____

9. *Length of time you perform an activity before it worsens*? ***mins* ____ *hrs*_____ *days***______

10. I feel worse **upon rising/early morning/late evening/mid-day/after work/time of month/**___________

11. Has there been any change in your bodily functions? (Urination, defecation, respiration, digestion, vision, sexual, other.) **YES** or NO. If Yes, describe: ____

12. Have you tried over the counter or home remedies? **YES** or NO. If Yes, describe: __________________

13. Have they helped? **YES** or NO. If Yes, describe: ____

14. Have you sought other professional care for this condition? **YES** or NO. If Yes, describe: ___________________
____

What did they prescribe and/or what treatment, care, or surgeries were rendered? _____________________________
____
____

Operations and Procedures

Approximate Date		Approximate Date		Approximate Date	
________	Vaccinations	________	Tubes in Ears	________	Sinus
________	Tonsillectomy	________	Appendectomy	________	Hernia
________	Gall Bladder	________	Female Organs	________	Thyroid
________	Back Operation	________	Rectal Surgery	________	Stomach
________	Other _______________	________	Other ________________	________	Other _______________

List any accidents or falls and dates: ☐ Car __________________ ☐ Recreational Vehicle ________________

☐ Sports __________________ ☐ School _______________ ☐ Other ________________________________

List any broken bones (fractures) or dislocations: ____

Ever on crutches? ☐ No ☐ Yes Why? ____

Have you ever had any spinal taps or spinal injections? ☐ No ☐ Yes

Have you ever had X-Rays taken? ☐ No ☐ Yes When? ______________ By whom? ____________________

For what ailments were these X-Rays made? ____

Have you ever had Osteoporosis or a Bone Density Test? ____

Do you suffer from any condition other than that for which you are now consulting us?__________________________

Patient Name____

15. Are you presently taking any medication - Prescription or over-the-counter? ☐ No ☐ Yes What drugs?
____

16. **Family History**

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, No. of ______	☐	☐	☐	☐	☐
Sister, No. of ________	☐	☐	☐	☐	☐

18. **Have You Had Any of the Following Diseases?**

☐ Tuberculosis ☐ Anemia ☐ Heart Disease ☐ Arthritis
☐ Diabetes ☐ Cancer ☐ Venereal Infection ☐ Epilepsy
☐ Mental Disorder ☐ Lumbago ☐ Eczema ☐ HIV Positive ☐ MRSA
☐ Any other infectious diseases______________

18. Please check the correct box for each item below. Check at least one box for each sign or symptom listed.

Never	Past	Presently	**Skin or Allergies**
☐	☐	☐	Boils
☐	☐	☐	Bruising Easily
☐	☐	☐	Hives or Allergy
☐	☐	☐	Itching
☐	☐	☐	Skin Eruptions

Never	Past	Presently	**Genito-Urinary**
☐	☐	☐	Bed Wetting
☐	☐	☐	Blood in Urine
☐	☐	☐	Frequent Urination
☐	☐	☐	Inability to Control Urine
☐	☐	☐	Kidney Infection
☐	☐	☐	Painful Urination
☐	☐	☐	Prostate Trouble

Never	Past	Presently	**Cardio-Vascular**
☐	☐	☐	High Blood Pressure
☐	☐	☐	Low Blood Pressure
☐	☐	☐	Pain over Heart
☐	☐	☐	Poor Circulation
☐	☐	☐	Previous Heart Trouble
☐	☐	☐	Rapid Heart
☐	☐	☐	Slow Heart
☐	☐	☐	Strokes
☐	☐	☐	Swelling Ankles

Never	Past	Presently	**For Women Only**
☐	☐	☐	Cramps or Backaches
☐	☐	☐	Excessive Flow
☐	☐	☐	Hot Flashes
☐	☐	☐	Irregular Cycle
☐	☐	☐	Miscarriage
☐	☐	☐	Painful Periods
☐	☐	☐	Vaginal Discharge
☐	☐	☐	Birth Control Pills

☐Yes☐No Pregnant at this time
Last Pap (Date) _______________
By Whom ___________________

Never	Past	Presently	**General Symptoms**
☐	☐	☐	Allergy (What) _____ ______________________
☐	☐	☐	Bronchitis
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of Sleep
☐	☐	☐	Excessive Loss of Weight
☐	☐	☐	Nervousness
☐	☐	☐	Neuralgia
☐	☐	☐	Night Sweats
☐	☐	☐	Numbness or pain in arms/legs/hands

Never	Past	Presently	**Eye/Ear/ Nose/Throat**
☐	☐	☐	Asthma
☐	☐	☐	Crossed Eyes
☐	☐	☐	Deafness
☐	☐	☐	Earache
☐	☐	☐	Ear Discharges
☐	☐	☐	Ear Noises
☐	☐	☐	Frequent Colds
☐	☐	☐	Hoarseness
☐	☐	☐	Nose Bleeds
☐	☐	☐	Pain in Eyes
☐	☐	☐	Poor Vision
☐	☐	☐	Sinusitis
☐	☐	☐	Sore Throats

Never	Past	Presently	**Gastro-Intestinal**
☐	☐	☐	Acid Reflux
☐	☐	☐	Hiatal Hernia
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall Bladder Trouble
☐	☐	☐	Jaundice
☐	☐	☐	Liver Trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over Stomach
☐	☐	☐	Poor Appetite
☐	☐	☐	Poor Digestion
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting Blood
☐	☐	☐	Belching or Gas
☐	☐	☐	Colon Trouble

Never	Past	Presently	**Muscles & Joints**
☐	☐	☐	Backache
☐	☐	☐	Foot Trouble
☐	☐	☐	Hip Trouble
☐	☐	☐	Knee Trouble
☐	☐	☐	Elbow Trouble
☐	☐	☐	Hand Trouble
☐	☐	☐	Painful Tail bone
☐	☐	☐	Stiff Neck
☐	☐	☐	Pain between shoulders
☐	☐	☐	Spinal Curvature
☐	☐	☐	Weakness
☐	☐	☐	Hernia
☐	☐	☐	Swollen Joints
☐	☐	☐	Tremors
☐	☐	☐	Twitching

Never	Past	Presently	**Respiratory**
☐	☐	☐	Chest Pain
☐	☐	☐	Chronic Cough
☐	☐	☐	Difficulty Breathing
☐	☐	☐	Spitting Blood
☐	☐	☐	Spitting Phlegm
☐	☐	☐	Wheezing

20. Presumed High Risk Presenting History Category
(George's Cerebrovascular Crainocervical Functional Test)
A. Arteriosclerosis
B. Transient ischemic attacks
C. Hypertension
D. Cardiovascular disease
E. Use of oral contraceptives (what kind and for how long)
F. Cervical spine spondylosis
G. History of "Whiplash" injury
H. Family history of strokes
I. Regular use of antihypertensive medication (e.g., coumidine, heparin, aspirin, etc.)

I give permission for Dr. Bradley and Good News Chiropractic to:

I understand that the consultation, exam, report of finding and or test adjustment do not necessitate the doctor accepting me as a patient. This will be decided before a treatment plan is started.

I give permission to Dr. Bradley along with the staff at Good News Chiropractic to examine and treat my condition as Dr. Bradley deems appropriate through the use of Chiropractic Health Care.________Initials

Get the records of my health care from my other treating doctors that pertains to the condition/s that Dr. Bradley is treating me for. ___Yes ___No ________Initials

Let my medical doctor know how my care is progressing ___Yes ___No ________Initials

Doctors Name(s)______________________________ Phone #(s)____

Let my friend/family who referred me to know how my care is progressing ___Yes ___No ________Initials

DATE ______________ Signature (Or Parent or Guardian) ____

DATE ______________ Signature of Doctor ____