*Glendale Chiropractic * New Patient Information Worksheet*

Name: _____ **SS#:** _____ **Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Birth Date:** _____

Employed By: _____ **Spouse Name:** _____

Spouse's Birth Date: _____ **Spouse's SS#:** _____

Your Email Address: _____

Referred By: (Friend) (Relative) (Newspaper Ad) (Yellow Pages) (Sign) (Other) _____

Which one of our patient's should we thank for referring you? _____

Please circle your current symptoms:

(Headaches) (Neck Pain) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain) (Upper Back Pain)

(Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain) (Sinus Problems) (Asthma) (Stomach Pain)

(Chest Pain) (Numbness) (Arthritis) (Sciatica) (Stress) (Other) _____

My symptoms are due to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

List all surgeries in the past 5 years: _____

Have you ever had spinal surgery? (No) (Yes) _____

List any serious condition the doctor should be aware of: _____

Previous Chiropractor: _____ **Were you satisfied?** (No) (Yes)

***Females: Are you pregnant at this time?** (No) (Yes) **Due Date:** _____

Office Policies: *If I am accepted as a patient at Glendale Chiropractic I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

Consent to Treat: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Brockway to proceed with any necessary treatment. I have read Dr. Brockway's office policies and consent to treat information, and I agree with them by signing below.*

Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Glendale Chiropractic Office

Dr. John Brockway * Email: drjohn@GlendaleCOChiropractic.com
Phone: (720) 889-1659 * Fax: (720) 889-2873
425 S. Cherry St., Ste. 307
Glendale, CO 80246-1230

Patient's Name: _____ **Date:** _____

Please circle the number which most closely describes your chief complaint(s) today:

1. Pain Intensity

(0)	(1)	(2)	(3)	(4)
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Frequency of Pain

(0)	(1)	(2)	(3)	(4)
No Pain	Occasional Pain 25% of the Day	Intermittent Pain 50% of the Day	Frequent Pain 75% of the Day	Constant Pain 100% of the Day

3. Personal Care (Washing, Dressing, Etc.)

(0)	(1)	(2)	(3)	(4)
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need some assistance	Severe Pain Need 100% Assistance

4. Travel (Driving, Riding, Etc.)

(0)	(1)	(2)	(3)	(4)
No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

(0)	(1)	(2)	(3)	(4)
Can Do Usual Work Plus Extra Work	Can Do Usual Work No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

(0)	(1)	(2)	(3)	(4)
No Pain No Restrictions	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need some assistance	Severe Pain Need 100% Assistance

7. Sleeping

(0)	(1)	(2)	(3)	(4)
Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

8. Lifting

(0)	(1)	(2)	(3)	(4)
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight

9. Walking

(0)	(1)	(2)	(3)	(4)
No Pain Any Distance	Increased Pain After One Mile	Increased Pain After Half Mile	Increased Pain After Quarter Mile	Increased Pain With All Walking

10. Standing

(0)	(1)	(2)	(3)	(4)
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After One Hour	Increased Pain After Half Hour	Increased Pain With Any Standing

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Patient Health History Worksheet

Patient's Name: _____ Date: _____

Significant Past Health History

Have you ever been hospitalized?
a) No
b) Yes: (Year: _____) (Reason: _____)

Have you had any surgeries?
a) No
b) Yes: (Year: _____) (Reason: _____)

Do you have any significant health problems?
a) No
b) Yes: (_____)

Significant Past Medical History

Have you seen another doctor for this condition?
a) No
b) Yes: (Name: _____)

Did this doctor recommend any treatment?
a) No
b) Yes: (_____)

Are you taking any medications?
a) No
b) Yes: (_____)

Significant Past Social History

Do you play any sports or exercise?
a) No
b) Yes: (_____)

How many hours do you sleep at night? (_____)

How many hours a week do you work? (_____)

Significant Family Medical History

Did your father have any health problems?
a) No
b) Yes: (_____)

Did your mother have any health problems?
a) No
b) Yes: (_____)

Did your brother(s) have any health problems?
a) No
b) Yes: (_____)

Did your grandpa have any health problems?
a) No
b) Yes: (_____)

Did your grandma have any health problems?
a) No
b) Yes: (_____)

Health Risk Factors

Do you drink alcohol?
a) No
b) Yes: (_____)

Do you smoke?
a) No
b) Yes: (_____)

Anything else the doctor should know about?
a) No
b) Yes: (_____)

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Patient Health History Worksheet

Patient's Name: _____ Date: _____

Present Health History

When did your present condition begin?
a) Gradual Onset (no specific date)
b) Date:

What caused your present condition?
a) No specific injury
b) Home accident
c) Work accident
d) Auto accident

What happened to cause your current pain?
_____
_____
_____
_____
_____

Have you ever had these symptoms before?
a) No
b) Yes: (Date: _____)

What time of day are your symptoms **better**?
a) Morning
b) Afternoon
c) Evening
d) None of the above (constant pain)

What time of day are your symptoms **worse**?
a) Morning
b) Afternoon
c) Evening
d) None of the above (constant pain)

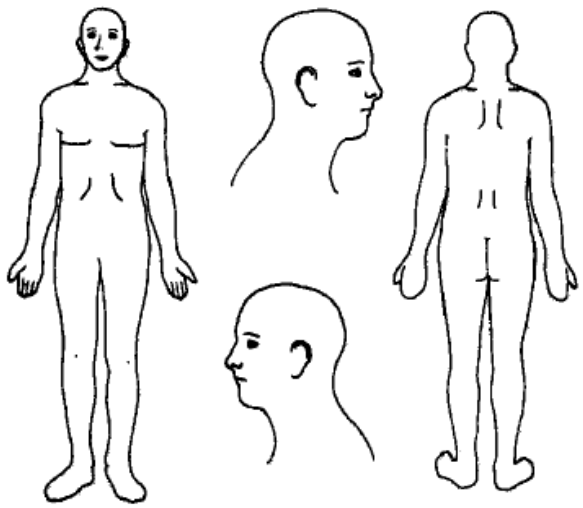
Have you missed any work from this condition?
a) No
b) Yes (Date: _____)

What makes your pain **better**?
a) Rest
b) Ice packs/Heating pads
c) Prescription Medications
d) Drug store medications (Ibuprofen, Advil)
e) Other: _____

What makes your pain **worse**?
a) Activity (work, repetitive motions)
b) Ice packs/Heating pads
c) Driving or riding in car
d) Other: _____

What home remedies have you tried?
a) Ice packs
b) Heating pads/Hot tub
c) Exercise
d) Other: _____

Please Label the Areas of Today's Pain



_____
_____
_____
_____
_____

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Assignment and Instructions for Direct Payment

Memo To: _____ Insurance Company

I hereby instruct and direct my present group health and/or automobile insurance company (or, **any third-party insurance company**) to pay by check made out and mailed directly to:

Dr. John Brockway, D.C.
425 S. Cherry St., Ste. 307
Glendale, CO 80246-1230

If any policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to ***me and the doctor*** and mail as follows:

_____ and Dr. John Brockway, D.C.
(Patient's Name) (Doctor's Name)
425 S. Cherry St., Ste. 307
Glendale, CO 80246-1230

This assignment is for the professional and/or medical expense benefits allowable, and otherwise payable to me under any insurance policy as payment toward the allowable charges for professional services rendered.

I authorize the release of any information pertinent to my case to any insurance company, claims representative, or attorney involved in this case.

I also authorize Dr. Brockway to initiate a complaint to any insurance company (for any reason) on my behalf.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY POLICY AND/OR ANY THIRD-PARTY POLICY.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL ASSIGNMENT.

I agree to pay, in a current manner, any balance for professional services not covered by any insurance company (deductibles, co-payments, non-covered services and supplies).

Approved By:_____ Date: _____
(Patient's Signature)