Johnson Chiropractic Clinic

Dr. Keith M. Johnson
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EXPERIENCED • COMMITTED • RESPECTED

General Information

Please complete the following sections:

a. Last Name: _____ First Name: _____ M. I. _____
b. Gender: ☐ Male ☐ Female
c. Age: _____ Date of Birth: (MM/DD/YYYY) _____
d. Street Address: _____
e. City: _____ State: _____ Zip: _____
f. Cell Phone Number: _____ Other Phone Number: _____ (Circle: Home/Work)
g. Email address: _____
h. Who referred you to our Clinic? _____
i. Is your illness or injury related to: ☐Workmen Compensation Claim ☐Auto Accident Claim ☐Other

Current Symptoms

Please list up to 4 main areas of concern (low back, neck, headaches, wrist, etc) in order of importance:

1. Area of greatest concern: _____ Date you first noticed this pain: _____
a. Circle the number or word on the scale that best reflects your pain: None 1 2 3 4 5 6 7 8 9 Severe
b. How much of the time do you feel pain? 0%-25% 26%-50% 51%-75% 76%-100%
c. How did this reason or condition happen?
☐ Illness ☐ Injury ☐ Auto Accident ☐ I don't know ☐ Other: _____
d. Heat: ☐ Better ☐ Worse Cold: ☐ Better ☐ Worse Resting: ☐ Better ☐ Worse Activity: ☐ Better ☐ Worse Other: _____ ☐ Better ☐ Worse

2. Second area of concern: _____ Date you first noticed this pain: _____
a. Circle the number or word on the scale that best reflects your pain: None 1 2 3 4 5 6 7 8 9 Severe
b. How much of the time do you feel pain? 0%-25% 26%-50% 51%-75% 76%-100%
c. How did this reason or condition happen?
☐ Illness ☐ Injury ☐ Auto Accident ☐ I don't know ☐ Other: _____
d. Heat: ☐ Better ☐ Worse Cold: ☐ Better ☐ Worse Resting: ☐ Better ☐ Worse Activity: ☐ Better ☐ Worse Other: _____ ☐ Better ☐ Worse

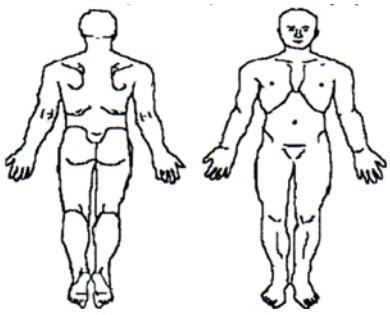
3. Third area of concern: _____ Date you first noticed this pain: _____
a. Circle the number or word on the scale that best reflects your pain: None 1 2 3 4 5 6 7 8 9 Severe
b. How much of the time do you feel pain? 0%-25% 26%-50% 51%-75% 76%-100%
c. How did this reason or condition happen?
☐ Illness ☐ Injury ☐ Auto Accident ☐ I don't know ☐ Other: _____
d. Heat: ☐ Better ☐ Worse Cold: ☐ Better ☐ Worse Resting: ☐ Better ☐ Worse Activity: ☐ Better ☐ Worse Other: _____ ☐ Better ☐ Worse

4. Fourth area of concern: _____ Date you first noticed this pain: _____
a. Circle the number or word on the scale that best reflects your pain: None 1 2 3 4 5 6 7 8 9 Severe
b. How much of the time do you feel pain? 0%-25% 26%-50% 51%-75% 76%-100%
c. How did this reason or condition happen?
☐ Illness ☐ Injury ☐ Auto Accident ☐ I don't know ☐ Other: _____
d. Heat: ☐ Better ☐ Worse Cold: ☐ Better ☐ Worse Resting: ☐ Better ☐ Worse Activity: ☐ Better ☐ Worse Other: _____ ☐ Better ☐ Worse

Date _____

Please mark the areas of discomfort or pain on the figures using the symbol that best describes the feeling:

+++	Sharp or stabbing
◦◦◦	Pins and needles
vvv	Dull or aching
///	Numbness



Please check what best describes whether your pain or symptom(s) limit these activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Running	☐	☐	☐
Resting in bed	☐	☐	☐
Intercourse	☐	☐	☐
Computer work	☐	☐	☐
Normal work	☐	☐	☐
Household activities	☐	☐	☐
Recreational activities	☐	☐	☐
Other: _____	☐	☐	☐

Personal Information

a. Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married _____ yrs.

b. Children: ☐ No ☐ Yes, Number _____ Ages _____

c. Education: Number of years _____ College/Vocation _____

d. Trade Skills: _____

e. Military? ☐ Yes ☐ No Branch _____ Dates of Service _____

Training/Skills Learned: _____

f. Past Employment (i.e. type of work, duration of employment): _____

_____

g. Personal Habits: ☐ Coffee/Tea ☐ Alcohol ☐ Smoking

h. During what time of the day do you feel worst? _____

i. Do you sleep well? ☐ Yes ☐ No What are your normal sleeping hours? _____ to _____

j. Recreational/Social Participation (i.e. swim, ski, fish, hunt, snowmobile, travel, dance, etc.): _____

_____

k. Has present problem altered personal hobbies? ☐ Yes ☐ No If so, explain: _____

_____

l. Are you currently under the care of a medical doctor or other type of health care provider for any condition?

☐ No ☐ Yes, for _____

Name of Doctor _____ Phone number _____

m. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind? (List all with years.)

☐ No ☐ Yes, for _____

n. Do you exercise? ☐ No ☐ Yes, I do these activities: _____

How many days a week? _____ How many minutes per session? _____

Family History

❑ Autoimmune Disorders ❑ Cancer ❑ Heart Disease ❑ Mental Illness
❑ Arthritis ❑ Diabetes ❑ Kidney Disease ❑ Seizure Disorder

Mother _____Age _____ Health Status_____

Father _____ Age _____ Health Status _____

Brothers _____Health Status_____

Sisters _____ Health Status _____

Personal History

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

❑ Neck pain with difficulty swallowing
❑ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
❑ Leg pain that worsens with exercise but is relieved by resting
❑ Loss of feeling in inner thighs
❑ Back pain with urinary problems

Types of pain

❑ Sever pain interrupts sleep
❑ Constant pain that doesn't improve by changing positions or lying down

Current Conditions

❑ Unable to balance when walking
❑ Recent unexplained weight loss
❑ Recent progressive muscle weakness or shaking
❑ Recent or current fever over 102° F
❑ Loss of bowel or bladder control
❑ Blurred or double vision, dizziness, nausea, or faintness when neck is in certain positions
❑ Recent major accident such as a fall from height, whiplash, or blow to the head
❑ Memory loss after injury

Previously diagnosed condition/medical history

❑ Congenital bone or joint disorder
❑ Rheumatoid arthritis
❑ Severe degenerative arthritis
❑ History of compression fracture
❑ History of heart attack
❑ History of stroke or aneurysm
❑ Past history of cancer or currently diagnosed with cancer
❑ Diabetes with cold, burning, or numb feet
❑ Gout
❑ Lupus
❑ Ankylosing spondylitis
❑ Immune suppression such as from chemotherapy, organ transplant, etc.
❑ Three or more months use of steroid medications or intravenous drugs (past or recent)

List all prescription and over the counter medications, and nutritional/herbal supplements you are taking:

_____

_____

Contacts

The following person(s) may be contacted in the event of an emergency. Fill out at last one contact.

1) _____ _____
Name Relationship

_____ _____
Primary Phone *(Circle: Cell/Home/Work)* Optional Secondary Phone *(Circle: Cell/Home/Work)*

2) _____ _____
Name Relationship

_____ _____
Primary Phone *(Circle: Cell/Home/Work)* Optional Secondary Phone *(Circle: Cell/Home/Work)*

Additionally, I give permission for Johnson Chiropractic Clinic to verbally share the information I have checked with the family, friends, or others that I have identified above as being involved in my health care, care coordination, or payment of my health care. This does not authorize releasing copies of my records. I understand that in certain situations Johnson Chiropractic Clinic may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

Contact 1: ❑ Scheduling/Appointment Information ❑ Test Results ❑ Billing and payment information
❑ Medical Information, including my symptoms, diagnosis, medications, and treatment plan

Contact 2: ❑ Scheduling/Appointment Information ❑ Test Results ❑ Billing and payment information
❑ Medical Information, including my symptoms, diagnosis, medications, and treatment plan

Consent and Certification

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatment.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that if I am not eligible for coverage under the terms of my Health Plan as communicated to Johnson Chiropractic Clinic, I am liable for all charges for services rendered and I agree to pay in full. I authorize the release of any health information necessary to process this claim. A photocopy of this authorization shall be as effective and valid as the original. I authorize payment of medical benefits to the provider listed who accepts assignment through his/her contract with Health Plans or representative. I understand that I am responsible for all non-covered services, deductibles, copayments and of notifying Johnson Chiropractic immediately of any changes in insurance coverage. I authorize payment to be made directly to Johnson Chiropractic.

I certify that I have read the financial responsibility and assignments of benefits and understand its contents.

I certify that the above information is true and correct to the best of my knowledge, and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature: _____ **Date:** _____

If the patient required assistance to complete this form, sign name and state relationship (i.e., parent, translator) below:

Name: _____ **Relationship:** _____ **Date:** _____