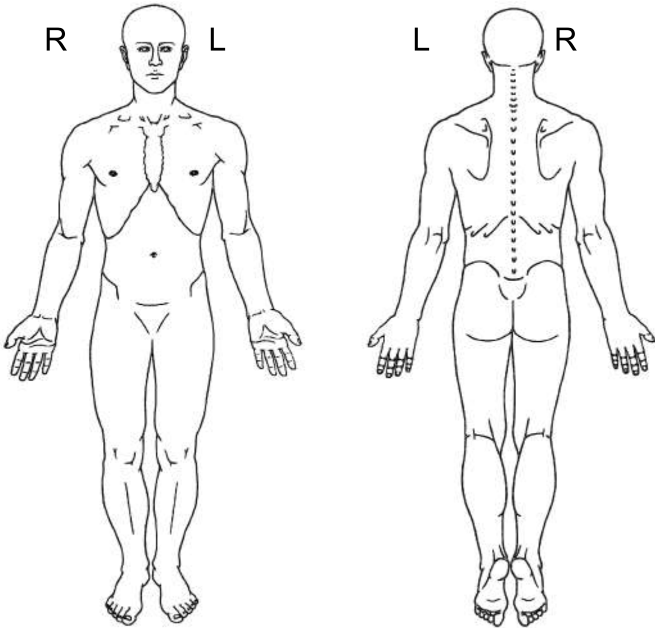
PATIENT HISTORY

Name ____ Date ___________________________________

Place the letters on the figure below to indicate the type and location of your present sensations

A= ache **B**= burning **N**= numbness
P= Pins & needles **S**= stabbing **O**= other



Please place a mark on the line below indicating your present level of pain, discomfort or other symptoms.

(If you have symptoms in multiple areas put a number from 1 to 10 and a % of how often you feel them on the body drawing to the left)

How often are your complaints present:

0-25% **26-50%** **51-75-%** **76-100%**

Please describe your major complaint with regards to the **type** your pain, discomfort or other symptoms. For example: dull, sharp, soreness, stiffness, throbbing, shooting, burning, spasm, weakness.

____

____

____

When was the first time you were aware of this problem? ____

On what specific date did the problem progress enough for you to seek treatment today? ______________________________

Did it begin? after a specific injury after multiple incidents gradually over time

Is this condition related to a Work injury Auto accident Slip and fall Sports injury Other _____________________

How did this condition develop? (What caused it? How did it start? What were you doing when it started?)________________

____

Since it began, is the pain? Increasing Decreasing Unchanging

What makes your condition better?____

What makes it worse?____

Has the condition altered your ability to work, play, or any of your daily activities? Yes No

If yes please explain: ____

____

What would you like to be able to do now that you can't because of the way you feel? ________________________________

____

PAST HISTORY

Have you ever had this problem or a similar problem before? Yes No If yes, when and what was the outcome? __________

____

Did you receive treatment? Yes No If yes, who did you see? ____

Have you consulted a chiropractor in the past? Yes No If yes, who? ______________________________________

Dates consulted ____________________________ For what problem? ________________________________

What surgeries have you had in the past? ____

Have you had any previous auto accidents, work or sports injuries? Yes No If yes, please explain _____________________

____

PLEASE CHECK OFF ALL PAST OR PRESENT SYMPTOMS

past present **HEAD**
[ ] [ ] Headaches
[ ] [ ] Dizziness
[ ] [ ] Tension
[ ] [ ] Fainting
[ ] [ ] Tired, Fatigue
[ ] [ ] Head feels heavy
[ ] [ ] Light bothers eyes
[ ] [ ] Loss of taste or smell

NECK
[ ] [ ] Neck pain
[ ] [ ] Neck stiffness
[ ] [ ] Neck spasms
[ ] [ ] Popping in neck

SHOULDER
[ ] [ ] Shoulder jt pain (R-L)
[ ] [ ] Tension in shoulders

ARM&HAND
[ ] [ ] Arm pain (R-L)
[ ] [ ] Arm numbness (R-L)
[ ] [ ] Wrist/hand pain (R-L)
[ ] [ ] Weak grip (R-L)
[ ] [ ] Elbow pain (R-L)
[ ] [ ] Cold hands

past present **MID-BACK**
[ ] [ ] Upper back pain
[ ] [ ] Pain between shoulder
[ ] [ ] Rib pain

CHEST
[ ] [ ] Chest pain
[ ] [ ] Shortness of breath
[ ] [ ] Breast pain

ABDOMEN
[ ] [ ] Heartburn
[ ] [ ] Stomach cramps
[ ] [ ] Nervous stomach
[ ] [ ] Food allergies _____
[ ] [ ] Gas
[ ] [ ] Constipation
[ ] [ ] Diarrhea
[ ] [ ] Nausea
[ ] [ ] Vomiting
[ ] [ ] Blood in stool [ ]
[ ] [ ] Hepatitis

FAMILY HISTORY
[ ] [ ] Cancer
[ ] [ ] Diabetes
[ ] [ ] Heart Disease
[ ] [ ] Arthritis

past present **LOWER BACK**
[ ] [ ] Lower back pain
[ ] [ ] Buttock pain
[ ] [ ] Muscle spasms
[ ] [ ] Lower back stiffness
[ ] [ ] Back feels tired
[ ] [ ] Pain increased by coughing

HIP,LEG&FOOT
[ ] [ ] Hip pain (R-L)
[ ] [ ] Pain in leg (R-L)
[ ] [ ] Knee pain (R-L)
[ ] [ ] Knee gives way
[ ] [ ] Leg cramps
[ ] [ ] Shooting pain in leg/foot (R-L)
[ ] [ ] Tingling in leg/foot (R-L)
[ ] [ ] Numbness in leg/foot (R-L)
[ ] [ ] Swollen ankles
[ ] Ankle/Foot pain (R-L)
[ ] [ ] Ankle sprain (R-L)

MISC.
[ ] [ ] Loss of bowel or bladder control
[ ] [ ] Loss of memory
[ ] [ ] Fever
[ ] [ ] Cancer

past present **WOMEN ONLY**
[ ] [ ] Menstrual pain
[ ] [ ] Cramping
[ ] [ ] Irregular cycle
[ ] [ ] Birth control _______type
[ ] [ ] Hysterectomy
[ ] [ ] Caesarean delivery

MEN ONLY
[ ] [ ] Urinary frequency
[ ] [ ] Difficulty starting urination
[ ] [ ] Painful urination

GENERAL
[ ] [ ] Nervousness
[ ] [ ] Irritable
[ ] [ ] Depression
[ ] [ ] Fatigue
[ ] [ ] Loss of sleep____hrs./night
[ ] [ ] Loss of weight ____lbs.
[ ] [ ] Gain of weight ____lbs.
[ ] [ ] Coffee ___cups/day Tea ___cups/day
[ ] [ ] Alcohol ___ drinks per week
[ ] [ ] Pain worse at night or at rest

Are you pregnant? Yes No If yes, what is your due date? ________________________________

Do you smoke? Yes ___ packs per day No If you quit smoking, when? ______________________

Are you taking any medications? Yes No What kind? ____________________________________

Do you take any vitamins or other supplements? Yes No What kind? _______________________

Do you exercise regularly? Yes No If yes, what type and how often? ______________________

____

________________________________ ____________________

Patient's Signature **Date**

WELCOME TO OUR OFFICE

Full Name ____________________________________ Nickname ______________ Date _____________________
Address ______________________________________ Apt. # _______ Age_____ Date of Birth _____/______/_____
City, State ____________________________________ Zip__________ Mobile/Cell Ph# ____________________
Work Ph# _______________________ Home Ph#__________________________

As part of your care in our practice may we add you to a subscriber to our website? We may send a welcome to our practice message & 1-2 monthly emails to help you get well and stay well. Unsubscribe at any time, your address will not be shared.

Email address _________________________________@______________________

Please choose appointment reminder preference, (you many check more than one) [ ] Text [ ] Voice message [ ] email

Gender: [ ] Female [ ] Male [ ] Transgender [ ] Other ___________

Relationship Status: [ ] Married [ ] Partnered [ ] Single [ ] Widowed [ ] Divorced [ ] Separated #of Children _______

Health has become global, as part of your Health History it is helpful to know

Where you were born? _____________________________ Your Ethnic origin?___________________________
Where have you traveled ? ____
Employer __________________________________ Employers Address __________________________________
Years Employed _____ Job Title __________________ Type of Work ___________________________________
Partner/Spouse's Name __________________________ Partner/Spouse's Employer______________________
Name of Insurance Company ______________________________________ Phone# ____________________
Are you insured through spouse, partner or parent? Yes No If so, who ? ____________________________
Their Date of Birth ___/___/___ Employer _______________________________________

Payment will be [ ] Cash [ ] Check [ ] Credit Card [ ] Workers' Comp [ ] Health Ins. [ ] Medicare [ ] Auto Ins. [ ] Lien

Who should we thank for your referral to our office? ____
Who is your Primary Care Physician? __________________________________ Phone: ____________________
Address __________________________________ Fax: ____________________

To help your first visit go smoothly here is what you can expect during approximately the next 45-75 minutes:

1. Paperwork Give your forms to the receptionist when you have completed them. The doctor will use this information to learn about your present health status. **If this visit is regarding an auto accident, a work injury or managed care please let us know, additional forms may be required.** Also take a moment to review and sign our financial policy.
2. Consultation You will meet the doctor, who will review your paperwork and discuss your health history and your present complaint. You will be advised of the cost of any office procedure.
3. Examination A complete examination will be performed. Afterwards the doctor will review the results and determine if Chiropractic can help you. When appropriate, you will be referred to other health care professionals or if X-rays are needed.
4. Initial Treatment If you are currently in pain, initial pain relief treatment will begin on your first visit. This may consist of any of the following:

Chiropractic Adjustment - The doctor will use a carefully directed and controlled pressure to begin restoring normal motion and position to the movable bones of your spine. You may feel or hear a slight pop or snap, which is due to joint movement.

Additional Therapy Procedures such as heat, ice, traction, electrical therapy, ultrasound, and diathermy. These procedures are helpful to reduce the pain, spasm, inflammation, or stiffness you may have.

5. Home Therapy The doctor may suggest home use of ice, heat, or stretching exercises, nutritional supplements, and orthopedic supports to reduce your discomfort.
6. Future Visits On your next visit plan to spend 30 - 45 minutes to receive the doctor's report of findings and additional treatment. You are always welcome to bring any family members or friends along so they can learn about your condition.

We hope this information will help to make your first visit more pleasant. If you have any questions don't hesitate to ask. If you were referred by one of our patients let them know we appreciate it.
After you have read this form please initial here. ___________________

JOHNSON CHIROPRACTIC OFFICE POLICY

We ask your cooperation in reading and signing this agreement, please initial that which applies:

_____ **I have insurance coverage *that covers* chiropractic** and understand that the insurance company does not always pay in full. I agree to pay the estimated portion at the end of each week or visit, depending on the frequency of my visits. Insurance billing is done as a courtesy to patients and I am ultimately responsible if the insurance company does not pay in full.

_____ **I have insurance coverage that *does not* cover chiropractic or has a high deductible.** Insurance billing is done as a courtesy to patients and I am ultimately responsible if the insurance company does not pay in full.

_____ **I do not have insurance coverage** and understand that payment in full will be required at the time of the visit or at the end of the week, depending on the frequency of my visits. Payment plans are also available.

_____ **I have Medicare.** I understand that Medicare requires an annual deductible, and a 20% co-pay. I understand that Medicare does not cover x-rays, which may be necessary.

_____ **I was injured in a motor vehicle collision or a slip and fall.** I have: (circle what applies)
Auto Medical Pay Coverage / An Attorney / Private Insurance / None of the above
Regardless of the coverage I understand that I am ultimately responsible for the bill.

_____ **I was injured on the job** and covered by worker's compensation. I am aware that if, for some reason, worker's compensation Insurance does not pay for my care, that I am ultimately responsible for my bill.

AS A CONDITION TO THE DOCTOR PROVIDING SERVICE TO ME, I AGREE TO THE FOLLOWING:

1. Returned checks are subject to a charge of $10.00
2. Balances past 30 days may be subject to an interest charge of 1.5% per month unless prior arrangements are made.
3. Payments are due 10 working days after the postmark of statements. Rebilling may be subject to a charge of $5.00.
4. Patients are responsible for any charges of collection, including but not limited to Attorney fees in the event of a delinquent account.

SCHEDULING:

Maintaining your appointment schedule is important. If you miss scheduled appointments, your care may be dismissed.
A $25.00 fee may apply unless a minimum of 24 hours is given. Emergencies are taken into consideration.

I have read this agreement and agree to its terms, I understand that I may request a copy if I desire.

_______________ ____________________________________
DATE PRINT PATIENT NAME

____
SIGNATURE OF PATIENT

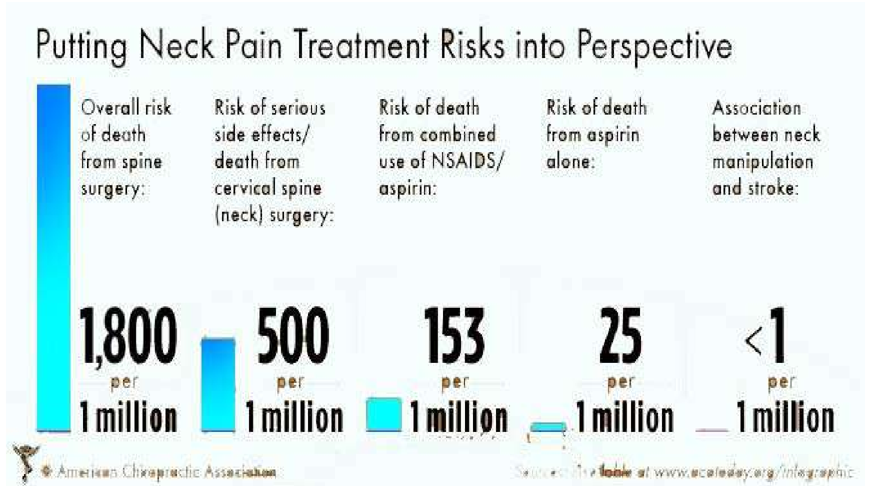
INFORMED CONSENT TO CHIROPRACTIC EVALUATION AND TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on myself (or the patient named below, for whom I am legally responsible) by Dr. Bob J. Johnson and or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with or associated with or serving as back-up for Dr. Bob J. Johnson including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Bob J. Johnson and /or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based on the facts then known, is in my best interests.

I have, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.



To be completed by patient:

To be completed by patient's representative, if necessary, if patient is a minor on physically or legally incapacitated:

____
Patient Name

____
Signature of Patient

____
Date Signed

____
Witness to Patient's Signature

____
Patient Name

____
Name of Patient's Representative

____
Signature of Patient's Representative

As:______________________________
Relationship or authority of Patient's Representative

____
Date Signed

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Your Doctor of Chiropractic is required by law to protect your health information for privacy and confidentiality. Please read it carefully.

We May disclose your health information regarding:

Treatment- to other healthcare professionals within our practice, substitute healthcare provider and or your primary care physician.
Payment- to insurance companies regarding payment or health care operations.
Workers Compensation- to comply with State Workers' Compensation Laws
Emergencies- to notify or assist your family/responsible person in case of injury or death.
Public Health- to public authorities for purposes of preventing/controlling disease, child abuse, reactions to medicines, and reporting disease or infection, for example.
Judicial and Administration Proceedings
Law Enforcement- to identify/locate a fugitive, material witness or missing person, subpoena compliance, etc.
Deceased Persons- to coroners or medical examiners.
Organ Donation- to organizations that procure, bank, or transplant organs and tissues.
Research- to researchers for research approved by an Institutional Review Board.
Public Safety- to prevent/lessen imminent threat to the public's health or safety.
Specialized Government Agencies- to military, national security, prisoner and Gov. benefits purposes.
Change of Ownership of this practice- to mergers or new owners
Referral Board- posting name on our referral board.
Your Health Information Rights- you may inspect and copy your health info, request restrictions on certain uses and disclosures, have your information received or communication through alternative methods, sent to alternative locations, amend your health information, receive full accounting of health info, and have a paper copy of this document after signature. Your Doctor of Chiropractic is not required to agree to restrictions, to amend your info, can deny or not amend upon your request, and will provide a formal explanation of reasons for denial, and information about how to disagree with the denial.
Changes to this Notice of Privacy Practices- Your Doctor of Chiropractic can amend this document. If you have questions regarding anything in this document you can contact Helen Klein at 858-578-5775 or make a personal appointment within 2 working days.
Complaints- Contact Office Manager at 858-578-5775 or make a personal appointment within 2 days. Further complaints can be directed to DHHS, Office of Civil Rights, 200 Independence Ave, S.W., Room 509F HHH Bldg, Washington, DC 20201

I have read the Privacy Notice and understand my rights and authorize Doctor Johnson, to use and disclose my protected health care information for treatment, payment, and healthcare operations as described above.

_______________ ____________________ _____________________
Date Patient's Name (print) Patient's Signature

____
Your Doctor of Chiropractic Officer Signature