

PATIENT INFORMATION

Thank you for choosing Johnson Family Chiropractic Clinic for your chiropractic needs. Please complete form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. (Please Print)

Name _____ S/S _____ - _____ - _____ Date _____
Address _____ City _____ State _____ Zip _____
Sex (circle) Female Male Date of Birth ____/____/____
Home phone # (____) _____ Work # (____) _____ Cell # (____) _____
Email address: _____ Who referred you? _____
I am: (circle one) a minor Married Divorced Widowed Single Separated
Your Employer _____ Occupation _____
Business Add _____ City _____ State _____ Zip _____
Spouse or Parent's name _____ Employer _____ Phone _____
Person to contact in case of emergency _____ Phone # (____) _____

INSURANCE INFORMATION

Primary - (present card to receptionist)

Insurance _____ Primary Insured Name _____
Policy #/ SS# _____ Date of Birth ____/____/____

Secondary - (present card to receptionist)

Insurance _____ Primary Insured Name _____
Policy #/ SS# _____ Date of Birth ____/____/____

CHIROPRACTIC TREATMENT CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk 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 treatment concerning which treatment(s) are in my best interests, based upon the facts as they are then known.

X _____ / ____/____
Signature of Patient (or parent if a minor) **Date**

AUTHORIZATION/FINANCIAL RESPONSIBILITY

I authorize the chiropractor to release any information concerning my diagnosis and medical records about any treatment or examination rendered to me or my child during the period of chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay the chiropractor directly for insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents. I understand that payment for services and/or the applicable copayment is due at the time of service.

X _____ / ____/____
Signature of Patient (or parent if a minor) **Date**

CURRENT CONDITION

What are your objectives in visiting the chiropractor?

If you are here due to pain, please describe what you were doing when the pain first occurred.

Describe what your pain feels like.

What do you do to relieve the pain? _____

Please list any major accidents, falls or injuries within the approximate date.

How do the following activities change your pain and what duration of time can you tolerate each activity?

	No Change	Relieves	Increased	Duration
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Looking Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Turning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1-10, rate the severity of your pain. If your pain fluctuates please mark both and indicate approximately the % of time at each level Example 0 1 2 3 4 5 6 7 8 9 10

	70%							30%			
	No Pain							Severe Pain			
	0	1	2	3	4	5	6	7	8	9	10
Neck Pain											
Mid Back Pain											
Low Back Pain											
Other											

If you have ever visited a chiropractor or chiropractors in the past, please list:

What did you like or not like about your previous treatment experiences?

Mark the areas on this body where you feel pain. Use the appropriate symbols.

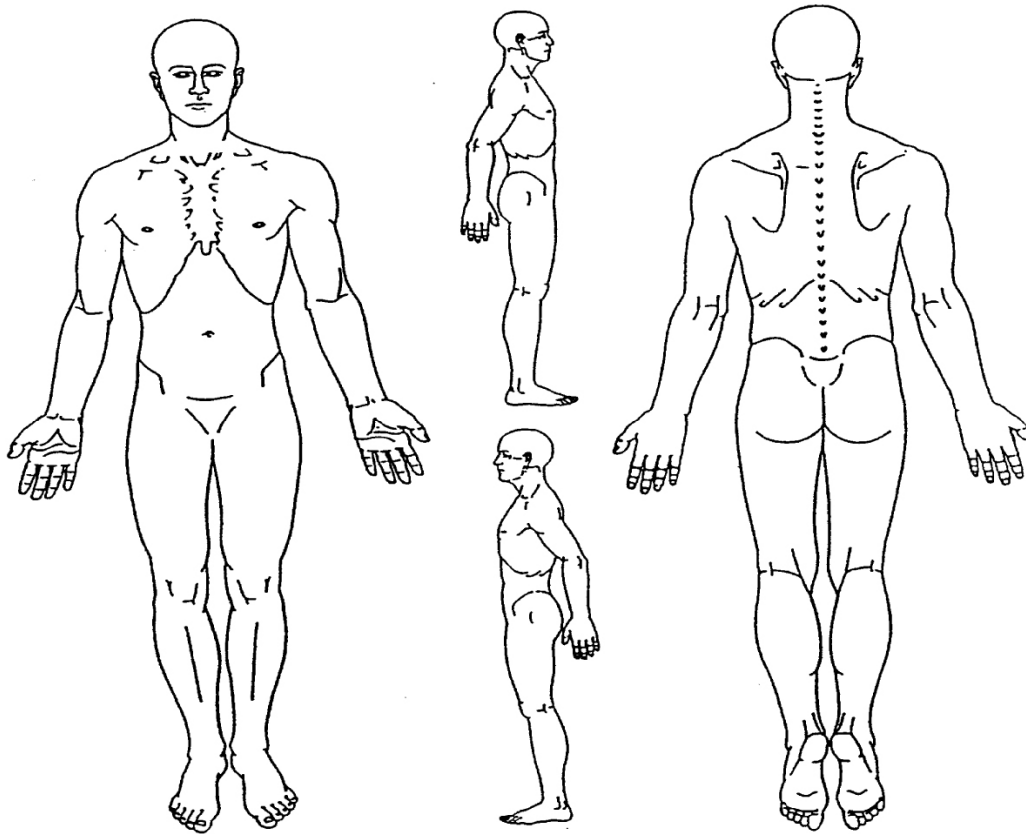
KEY:

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT

A = ACHE
N = NUMBING

B = BURNING
P = PINS & NEEDLES

C = STABBING
O = OTHER



Please give approximate date of last:

Spinal Exam _____ Physical Exam _____

Spinal X-Ray _____ Other Spinal Imaging _____

Doctor's Notes:

MEDICAL CONDITIONS/MEDICATION (use Y or N for Yes/No Answers)

Please list any medical conditions you are being treated for currently and what action is being taken: _____

List the main conditions for which you have been treated in the last 10 years.

Have you ever been hospitalized? _____ If yes, please list hospitalizations/surgeries:

Have you ever had a fractured bone? _____ If so which bones? _____

Do you take medications? If so, please list: _____

Do you take vitamins, herbs or other supplements? _____ If so, please list: _____

Are you interested in knowing what vitamins/supplements may benefit you? _____

Who is your Primary Care Physician? _____

Do you exercise? _____ If so, how many times per week? _____

Do you eat a balanced diet? _____ Do you eat many junk foods? _____

Are you interested in visiting with the chiropractor about achieving certain health goals? _____

If so, which health goals are you most interested in? _____

Is your sleep pattern irregular or restless? _____

Have any of the following occurred recently? (circle) increased work stress, family problems, death, divorce, change of job, chronic fatigue, anxiety, economic stress, other _____

Is your condition related to employment? _____ Yes _____ No

Is your condition related to an auto accident? _____ Yes _____ No

If "yes," please complete Personal Injury Questionnaire.

Would you like to receiving informational emails? _____ Yes _____ No

Please **UNDERLINE** all of the following conditions you have had **PREVIOUSLY**.
CIRCLE all of the following conditions you have **NOW**. Please sign and date form below.

GENERAL

Headache
Fainting
Diabetes
Cancer
Fainting
Epilepsy
Dizziness
Convulsions
Weight loss
Weight gain
Allergy

E.E.N.T.

Failing vision
Near sighted
Far sighted
Crossed eyes
Deafness
Earache

RESPIRATORY

Chronic cough
Pneumonia
Pleurisy
Asthma

SKIN

Skin eruptions
Varicose veins
Sensitive skin
Hives
Eczema

CARDIO-VASCULAR

Rapid heart beat
Slow heart beat
High blood pressure
Low blood pressure
Previous heart stroke
Hardening of arteries
Swelling of ankles

MUSCLE/JOINT

Head injury
Spinal injury
Tail bone injury
Shoulder / elbow
Wrist / hand

Hip / knee
Ankle / foot
Spinal / curvature
Faulty posture
Arthritis
Polio
Gout
Swollen joints
Hernia
Chronic fatigue
Fibromyalgia

GENTOURINARY

Frequent urination
Painful urination
Kidney infection/stone
Bed wetting
Inability to control urine
Prostate trouble

GASTROINTESTINAL

Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Stomach pain
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis
Irritable bowel

FOR WOMEN ONLY

Painful menstrual periods
Excessive flow
Hot flashes
Cramps or backache
Previous miscarriage
Lumps in breast
Menopausal symptoms
Are you pregnant?
Yes _____ No _____

PATIENT SIGNATURE:

DATE:
