Patient Name:_____ Date:_____

Chiropractic Intake Form

Chief Complaint:

What brings you to the office today? _____

When did it begin? _____

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Other _____

Please explain: _____

How are your symptoms changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

Are you currently or have you previously been treated for this problem? ☐ Y ☐ N

By whom: _____

Type of Treatment: _____

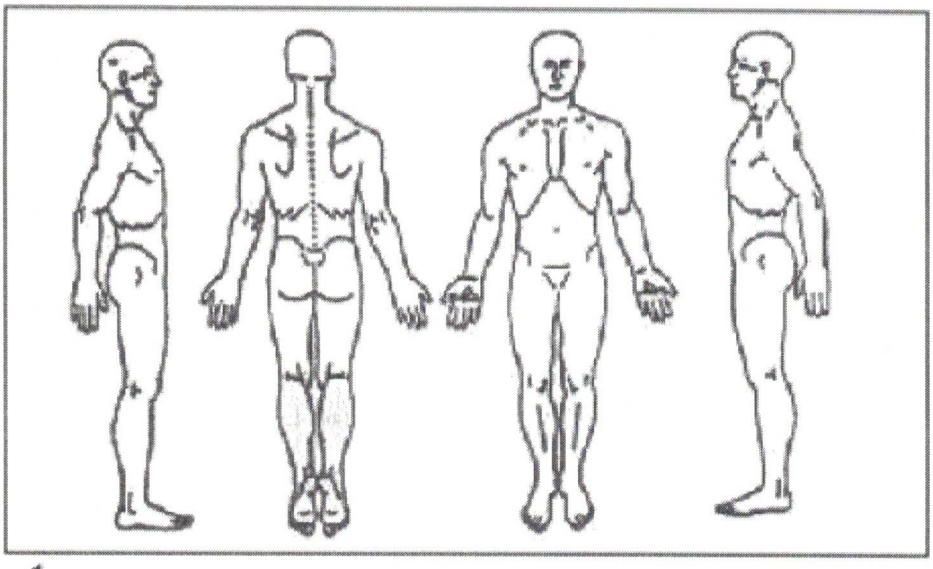
Is your condition due to an accident? ☐ Yes ☐ No Date of Accident: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other _____

To who have you reported your accident?

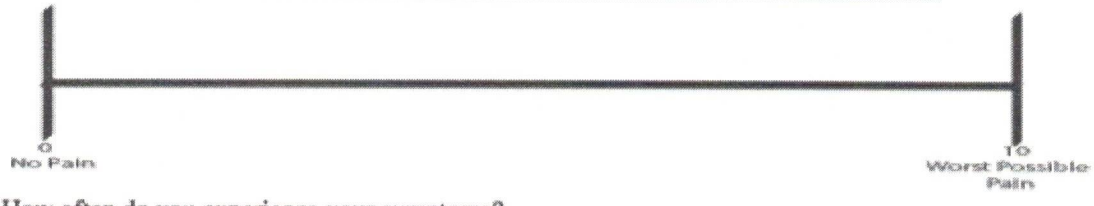
☐ Auto Insurance ☐ Employer ☐ Workers Comp. ☐ Other _____

Attorney Name (if applicable): _____



Please draw location and type of pain on body outline.

Ache ^^^^^^ ^^^	Burning = = = = = = = = = =
Numbness oooooooo oooo	Pins and Needles ....
Stabbing ////// ////	Other xxxxxx xxx



Please indicate level of pain on line with a mark

How often do you experience your symptoms?

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

Have you had these symptoms in the past? ☐ Yes ☐ No

Have you had any testing for your condition?

☐ X-Rays ☐ MRI ☐ CT Scan ☐ Other _____

When were these tests performed? _____

Dr.'s Initials: _____

Confidential Patient Case History

NAME:_____ **SIGNATURE:** _____ **DATE:**_____

Please mark the appropriate box for any of the symptoms you have or have had in the past. This assists Dr. Johnson determine if Chiropractic care can help with your condition(s). THIS IS A CONFIDENTIAL HEALTH REPORT.

O=Occasional F=Frequent C=Constant

O	F	C	General
			Allergy
			Anxious
			Chills
			Convulsions
			Dizziness
			Fatigue
			Fever
			Headache
			Loss/sleep
			Loss/weight
			Depression
			Neuralgia
			Numbness
			Sweats
			Tremors
			MUSCLE & JOINT
			Arthritis
			Bursitis
			Foot pain
			Hernia
			Back pain
			Neck pain
			Pain/Numb:
			Shoulders
			Arms
			Elbows
			Hands
			Hips
			Hands
			Legs
			Knees
			Feet
			Pain/Tail Bone
			Poor Posture
			Sciatica
			Spine Curved
			Swollen Joints

O	F	C	GastroIntestinal
			Belching/Gas
			Colitis
			Colon problem
			Constipation
			Diarrhea
			Difficult Digestion
			Distension of abdomen
			Excessive hunger
			Gallbladder problem
			Hemorrhoids
			Intestinal parasite
			Jaundice
			Liver problem
			Nausea
			Pain over Stomach
			Poor appetite
			Vomitting
			Vomitting blood
			Eyes, Ears, Nose, Throat
			Asthma
			Colds
			Crossed eyes
			Deafness
			Dental decay
			Earache
			Ear discharge
			Ear noises
			Enlarged glands
			Enlarged thyroid
			Eye pain
			Failing vision
			Far sighted
			Gum problem
			Hay Fever
			Hoarseness
			Nasal obstruction
			Near sighted
			Nosebleeds
			Sinus infection
			Sore throat
			Tonsilitis

O	F	C	Cardiovascular
			Hardening/arteries
			High Blood Pressure
			Low Blood Pressure
			Pain over Heart
			Poor circulation
			Rapid Heart Rate
			Slow Heart Rate
			Ankle Edema
			Respiratory
			Chest Pain
			Chronic cough
			Difficult Breathing
			Spitting up Blood
			Spitting up Phlegm
			Wheezing
			Skin
			Boils
			Bruise easily
			Dryness
			Hives
			Itching
			Rash
			Varicose Veins
			Genitourinary
			Bed wetting
			Blood in Urine
			Frequent Urination
			Inability to control Urination
			Kidney infection/stones
			Painful urination
			Pus in Urine
			FOR WOMEN ONLY:
			Fibrocystic Brests
			Cramps
			Excessive Menstrual Flow
			Hot Flashes
			Irregular cycle
			Menopausal symptoms
			Painful menstruation
			Vaginal discharge
	Yes		No ARE YOU PREGNANT?

Johnson Chiropractic Center

Dr. Stephen Johnson

**Is there any possibility you are pregnant? Yes/No Date of last menstrual cycle _____

Health History – Circle all that apply

AIDS/HIV	Allergy Shots	High BP	Anorexia	Prosthesis	Diabetes
Breast Lump	Bronchitis	Anemia	Cancer	Goiter	V.D.
Emphysema	Epilepsy	Bulimia	Glaucoma	Fibromyalgia	Heart Disease
Migraines	Hernia	Fractures	Herpes	Arthritis	Measles
Pacemaker	Miscarriage	Herniated Disc	High Cholesterol	Chicken Pox	Polio
Tonsillitis	Pneumonia	Mono	Mumps	Osteoporosis	COVID-19
Chronic Fatigue	Tuberculosis	Prostate Tumor	M.S.	Rheumatism	OTHER_____

Family History—List any diseases and conditions that are current health problems of family members: _____

----------CHIROOPRACTIC INFORMED CONSENT TO TREAT----------

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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic indicated above and/or other licensed Doctors of Chiropractic and support Staff who now or in the future treat me while employed by, working or associated with or serving as back up for the Doctor of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic , whether signatories to this form or not. I have had an opportunity to discuss with the Doctor of Chiropractic named above and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further 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, 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 procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers, physical therapy, steroid injections, bracing, and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and I have read, 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.

Initial _____

Patient Acknowledgement of Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his or her health information in a manner consistent with Notice of Privacy Practices Pursuant to HIPAA, the HIPASA Compliance Manual, State Law and Federal Law. **Initial** _____

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Johnson Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance directly to Johnson Chiropractic Center. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and for payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered will be immediately due and payable.

Signature _____ **Date** _____

OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our Staff.

2. This office may make payment plan arrangements on an individual basis, discussed between Dr. Johnson/Staff, and Patient.

INSURANCE

1. You are responsible for our entire bill should your insurance company not pay any part of the anticipated charges for any reason. We are not a mediator between your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.

2. Any services not covered, or coverage reductions, by your insurance will be the patient's responsibility.

3. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services, and you will be expected to pay such charges on a timely basis.

4. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full expected immediately, regardless of any claims submitted.

5. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance personnel prior to seeing the Doctor.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient's Signature Date

Johnson Chiropractic Center

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

Persons Authorized to use or Disclose Information

Information listed above will be used or disclosed by

Name of Person/Organization

Name of Person/Organization

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by the patient or patient's representative.

Patient Rights

Right to Terminate of Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment/payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Time

Witness Signature

Date

Modified Oswestry Low Back Pain Disability Questionnaire

Name:_____ Date: _____/_____/_____

Please Read:
This questionnaire has been designed to give your doctor/therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the **one** box that best describes your condition today.

We realize you may feel that two of the statements in any one section relate to you, but please just mark the box which most closely describes your current condition

Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me moderate relief from pain.
- ☐ Pain medication provides me little relief from pain.
- ☐ Pain medication has no effect on the pain

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care.
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if weights are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 - Walking
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ mile
- ☐ Pain prevents me walking more than ¼ mile
- ☐ I can only walk using crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting
- ☐ I can it in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 mins.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Even when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all

Section 8 – Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex sports, dancing, etc.
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Section 9 – Traveling
- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ Pain restricts travel over 2 hours.
- ☐ Pain restricts travel over 1 hour.
- ☐ Pain restricts my travel to short necessary journeys under ½ hour.
- ☐ Pain prevents all travel except for visits to the doctor/therapist or hospital.

Section 10 – Employment/Homemaking
- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. Lifting, vacuuming).
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job/homemaking chores.

NECK Pain and Disability Questionnaire

Rate the severity of your pain by circling one number: (No Pain) 0…1…2…3…4…5…6…7…8…9…10 (Excruciating Pain)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Read through each section and check only ONE line that applies to you. You may find that two of the statements in a section relate to you, but please just check ONE line that best describes your current predicament.

Section 1– Pain Intensity
___ I have no pain at the moment.
___ The pain is very mild at the moment.
___ The pain is moderate at the moment.
___ The pain is fairly severe at the moment.
___ The pain is very severe at the moment.
___ The pain is the worst imaginable at the moment.

Section 2– Personal Care (washing, dressing, etc.)
___ I can look after myself normally without causing extra pain.
___ I can look after myself normally but it causes extra pain.
___ I am slow and careful because it is painful for me to look after myself.
___ I need some help but manage most of my personal care.
___ I need help every day in most aspects of care.
___ I do not get dressed, I wash with difficulty and stay in bed.

Section 3– Lifting
___ I can lift heavy weight without extra pain.
___ I can lift heavy weight but it causes extra pain.
___ I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like on a table.
___ I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned.
___ I cannot lift any weight due to neck pain.

Section 4– Reading
___ I can read as much as I want to with no pain in my neck.
___ I can read as much as I want to with slight neck pain.
___ I can read as much as I want to with moderate neck pain.
___ I cannot read as much as I want to due to moderate neck pain.
___ I can hardly read at all because of severe neck pain.

Section 5– Headaches
___ I have no headaches at all.
___ I have slight headaches that occur infrequently.
___ I have moderate headaches that occur infrequently.
___ I have frequent moderate headaches.
___ I have frequent severe headaches.
___ I have severe headaches all the time.

Section 6- Concentration
___ I can concentrate fully when I want to with no difficulty.
___ I can concentrate fully when I want to with slight difficulty.
___ I have a fair degree of difficulty in concentrating when I want to.
___ I have a great deal of difficulty in concentrating when I want to.
___ I cannot concentrate at all.

Section 7- Work
___ I can do as much work as I want to.
___ I can only do my usual work, but no more.
___ I can do most of my usual work, but no more.
___ I cannot do my usual work.
___ I can barely do any work at all.
___ I cannot do any work at all.

Section 8- Driving
___ I can drive my car without any neck pain.
___ I can drive my car as long as I want with slight neck pain.
___ I can drive my car as long as I want with moderate neck pain.
___ I cannot drive my car as long as I want.
___ I can hardly drive at all because of severe neck pain.
___ I cannot drive my car at all.

Section 9- Sleeping
___ I have no trouble sleeping.
___ My sleep is slightly disturbed (less than 1 hour sleepless)
___ My sleep is mildly disturbed (1 hour sleepless)
___ My sleep is moderately disturbed (2 to 3 hours sleepless)
___ My sleep is greatly disturbed (4 to 5 hours sleepless)
___ My sleep is completely disturbed (6 to 7 hours sleepless)

Section 10- Recreation
___ I am able to engage in all my recreation activities with no neck pain.
___ I am able to engage in all my recreation activities with some neck pain.
___ I am able to engage in most, but not all of my usual recreation activities.
___ I am able to engage in a few of my usual recreation activities.
___ I can hardly do any recreation activities.
___ I cannot do any recreation activities due to neck pain.

Patient Name (Print) _____ Patient Signature _____ Date _____

FOR OFFICE USE ONLY:

_____ x 2 = _____

Total Points Disability Percentage Rating Scale