

PATIENT INFORMATION

Insurance Cash Medicare Worker's Comp Auto

Specific Problem _____		Date _____	
Name _____		Home Phone _____	
Cell Phone _____		Work Phone _____	
Address _____			
City _____		State _____	Zip _____
Occupation _____		Employer _____	
Social Security # _____ - _____ - _____		E-mail _____	
Date of Birth ____/____/____		Martial Status: M S W D How many children: _____	
Spouse's Name _____		Phone _____	
Emergency Contact _____		Phone _____	
Primary Physician _____		Phone _____	
Whom may we thank for referring you to us? _____			
Who is responsible for this account? _____		Relationship to Patient _____	
Is this complaint due to: Auto Accident Work Related Other _____			
Circle if applicable and complete information on back if Auto Accident or Worker's Compensation			

INSURANCE INFORMATION

Primary Insurance Company _____		Group No. _____	
Address _____		Phone _____	
Insured Name _____		Insured ID # _____	
Secondary Insurance Company _____		Group No. _____	
Address _____		Phone _____	
Insured Name _____		Insured ID _____	
Is this condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide date of accident _____			
Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other (Specify) _____			
To whom have you made a report of your accident? <input type="checkbox"/> Auto insurance <input type="checkbox"/> Employer <input type="checkbox"/> Other _____			
Contact Name _____		Report/Authorization No. _____	
Phone _____		Fax Number _____	

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I further understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will immediately be due and payable. I further certify that I have insurance coverage with _____ and assign directly to Jeffrey S. Johnson, D.C., D.A.C.N.B. all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____
Date

AUTO ACCIDENT

Date of Injury _____ Have you reported the accident? Yes No

Do you have automobile medical insurance? Yes No

Insurance Company _____ Policy Number _____

Adjuster Name _____ Phone Number _____

Additional automobile medical insurance? Yes No

Insurance Company _____ Policy Number _____

Adjuster Name _____ Phone Number _____

Do you have an attorney? Yes No

Did the police make a report? Yes No *(If yes, must provide a copy)*

Do you have any photo's of injury or damage to vehicle? Yes No *(If yes, must provide copies)*

WORKER'S COMPENSATION

Date of Injury _____ Have you reported the accident? Yes No

Supervisor Name _____ Phone _____

Have you been authorized to utilize our services? Yes No

Insurance Company _____ Claim Number _____

Adjuster Name _____ Phone _____

**If you have ever experienced a condition in your past, please check past.
If you are currently experiencing a condition, please check present.**

Past Present

MUSCULO-SKELETAL

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw

NERVOUS SYSTEM

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Changes in Handwriting
- Irritability
- Changes in Personality

GENERAL

- Allergies
- Loss of Sleep
- Fatigue

- Fever
- Headache

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R

- Chest Pain
- Shortness of Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes
- Menopause

FAMILY HISTORY:

Mother: Cancer Diabetes Heart High Blood Pressure Respiratory Problems Kidney Stroke In Good Health
If Deceased-Age at Death _____

Father: Cancer Diabetes Heart High Blood Pressure Respiratory Problems Kidney Stroke In Good Health
If Deceased-Age at Death _____

Siblings: Cancer Diabetes Heart High Blood Pressure Respiratory Problems Kidney Stroke In Good Health
If Deceased-Age at Death _____

SOCIAL HISTORY:

- Marital Status: Single Married Divorced Widowed
- Number of Children: 1 2 3 4 5 6 7 8 None
- Do You: Exercise Regularly Eat a Balanced Diet Obtain Sufficient Rest
- Indicate your level of Exercise Regularly Weekend Warrior Professional Athlete Athlete in Training None
- Do You Smoke: No Less than 1 1-2 2-3 3-4 More than 5 (packs/day)
- Do You Drink Coffee/Tea: No Occasionally 1-2 2-3 3-4 More than 5 (cups/day)
- Do You Drink Alcohol: No Occasionally 1-2 2-3 3-4 More than 5 (drinks/day)

OCCUPATIONAL HISTORY:

Nature of Work _____

Primary Positions Required: Sitting Standing Walking Driving Other _____

Repetitive Activities _____

Dr's Notes: _____

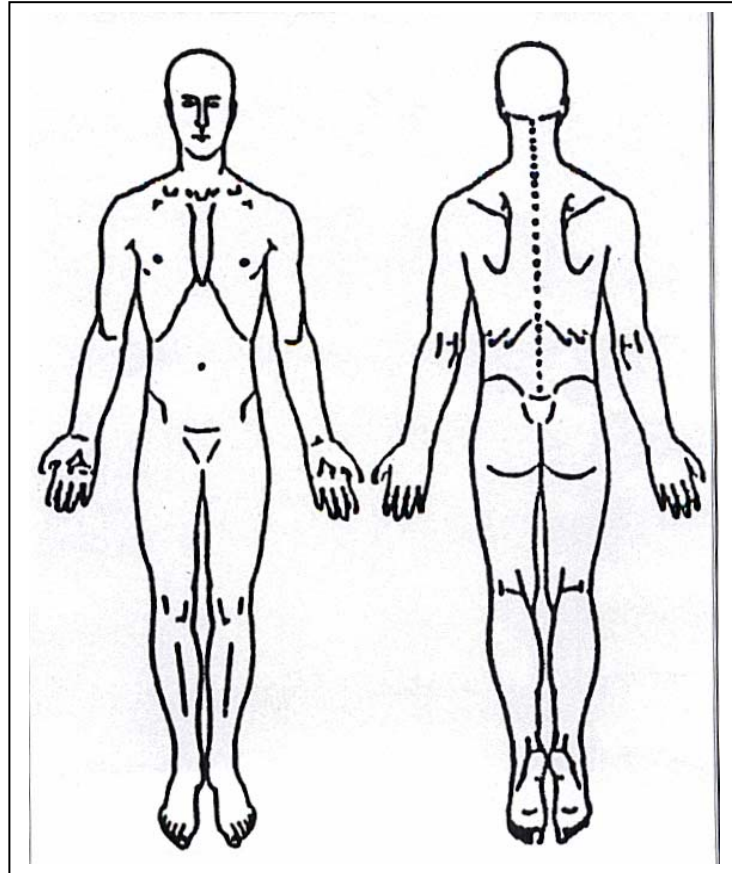
On the Diagram at the right, please indicate where you are experiencing pain right now. (Please mark the exact location of your pain on the diagrams using the abbreviations listed below.)

- Pain = **P**
- Tingling = **T**
- Numbness = **N**
- Burning = **B**
- Stiffness = **S**

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | |
|--|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Lumbar |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Small Pox | |



List any serious illnesses you have had that are not listed above: _____

List any birth defects: _____

List any hospitalizations and surgeries: _____

List any injuries for which you were not hospitalized: _____

MEDICATIONS:

List all medications that you are currently taking or have taken on a regular basis in the last 6 months (include home remedies).

_____	_____
_____	_____
_____	_____

MEDICATIONS TO WHICH YOU ARE ALLERGIC:

_____	_____
_____	_____