

PATIENT INFORMATION

Insurance Cash Medicare Worker's Comp Auto

Specific Problem _____ Date _____

How did you hear about us?

Forward Motion Yelp Diablo Magazine Yellow Pages Current Promotion _____

Personal / Dr. Referral Who referred you? _____ Other _____

Name _____ Home Phone _____

Cell Phone _____ Work Phone _____

Address _____

City _____ State _____ Zip _____

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 _____

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? Yes No If yes, provide date of accident _____

Type of accident Auto Work Home Other (Specify) _____

To whom have you made a report of your accident? Auto insurance Employer 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. **I understand that all appointment cancellations must be made 24 hours in advance to avoid a cancellation fee of \$25 per scheduled session. In the event of a cancellation your credit card will be appropriately charged.**

Visa / MC # _____ Exp. Date _____ Security Code _____

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 <input type="checkbox"/> Present MUSCULO-SKELETAL <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Pain Between Shoulders <input type="checkbox"/> Neck Pain <input type="checkbox"/> Arm Pain <input type="checkbox"/> Joint Pain/Stiffness <input type="checkbox"/> Walking Problems <input type="checkbox"/> Difficulty Chewing/Clicking Jaw NERVOUS SYSTEM <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Dizziness <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Confusion/Depression <input type="checkbox"/> Fainting <input type="checkbox"/> Convulsions <input type="checkbox"/> Cold/Tingling Extremities <input type="checkbox"/> Changes in Handwriting <input type="checkbox"/> Irritability <input type="checkbox"/> Changes in Personality GENERAL <input type="checkbox"/> Allergies <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever <input type="checkbox"/> Headache GASTRO-INTESTINAL <input type="checkbox"/> Poor/Excessive Appetite <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Frequent Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Liver Trouble <input type="checkbox"/> Gall Bladder Problems <input type="checkbox"/> Weight Trouble <input type="checkbox"/> Abdominal Cramps <input type="checkbox"/> Gas/Bloating After Meals <input type="checkbox"/> Heartburn <input type="checkbox"/> Black/Bloody Stool <input type="checkbox"/> Colitis GENITO-URINARY <input type="checkbox"/> Bladder Trouble <input type="checkbox"/> Painful/Excessive Urination <input type="checkbox"/> Discolored Urine | C-V-R <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Blood Pressure Problems <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Problems <input type="checkbox"/> Lung Problems/Congestion <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Ankle Swelling EENT <input type="checkbox"/> Vision Problems <input type="checkbox"/> Dental Problems <input type="checkbox"/> Sore Throat <input type="checkbox"/> Ear Aches <input type="checkbox"/> Hearing Difficulty <input type="checkbox"/> Stuffed Nose MALE/FEMALE CODE <input type="checkbox"/> Menstrual Irregularity <input type="checkbox"/> Menstrual Cramping <input type="checkbox"/> Vaginal Pain/Infections <input type="checkbox"/> Breast Pain/Lumps <input type="checkbox"/> Prostate/Sexual Dysfunction <input type="checkbox"/> Genital Herpes <input type="checkbox"/> 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: _____

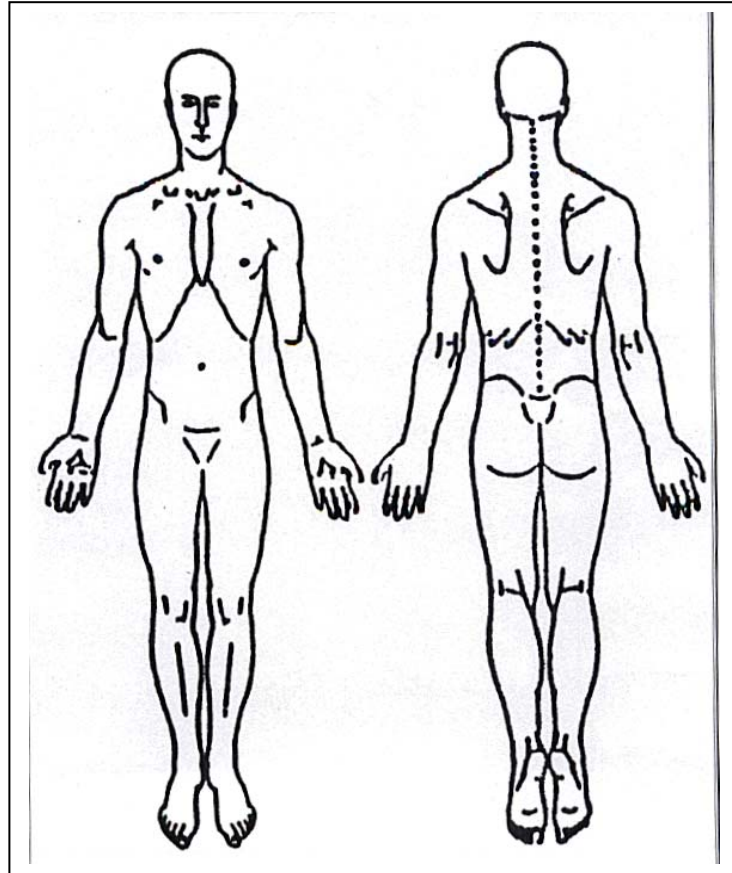
On the Diagram at the right, please indicate where you are experiencing pain right now. (Please mark the exact location of your pain on the diagrams using the abbreviations listed below.)

- 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:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |