Welcome to Johnson Chiropractic Center

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please ask for assistance. We will be happy to help.

Name_____ Date_____

Address_____ City_____ State____ ZIP_____

Sex: ___Female ___Male SSN_____-_____-_____ Birthdate _____

Phone Home _____ Cell _____ Work _____ Email _____

Do you prefer to receive calls at Home___ Work___ Cell___ Either___

Employer_____ Occupation_____

Employer address_____ City_____ State____ ZIP_____

Are you: ___Minor ___Married ___Divorced ___Widowed ___Single ___Separated

Spouse's or Parent's Name_____ Workplace_____ Phone_____

Legal Guardian (if other than above)_____ Phone_____

Emergency contact_____ Phone_____

Whom may we thank for your referral?_____

Responsible Party

Name of person responsible for this account_____

SSN_____-_____-_____ Birthdate _____

Relationship to patient?_____ Phone_____

Address_____ City_____ State____ ZIP_____

Insurance

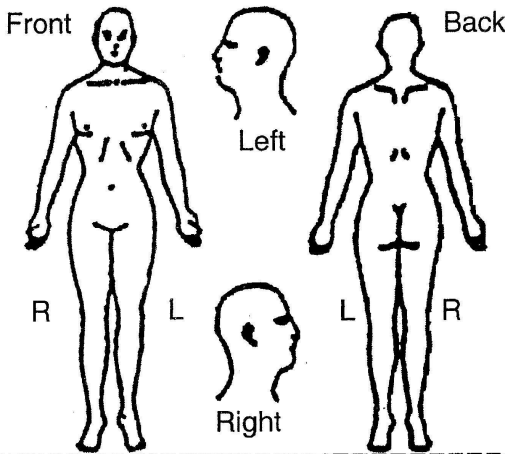
Insured's Name_____ Date of birth_____

Symptoms

Reason for today's visit_____ Is this condition getting worse?_____

When did you first notice this condition?_____ Where is the problem located?_____

PLEASE INDICATE THE AREA OF YOUR SYMPTOMS ON THE FIGURE TO THE LEFT.



Which activities are difficult to perform?

___Sitting ___Standing ___ Walking ___Bending ___Lying down

Type of pain:

__Sharp __Dull __Throbbing __Numb __Ache __Shooting __Burning

__Cramps __Swelling __Tingling __Stiffness __Other

Rate your pain (1-mild; 10-most severe): 1 2 3 4 5 6 7 8 9 10

Is the pain (circle one): Constant Comes-and-goes

What treatments have you already received for your condition? ___Medication ___Surgery ___Physical Therapy ___Other

Names of other doctors who have treated you:_____

_____

Dates of last exams_____ List any surgeries & dates they occurred_____

_____

List all medications_____

Daily Habits

What type of activity do you perform on a daily basis? ___None ___Moderate ___Heavy

Describe your daily work activities (Sitting, Standing, Computer, heavy labor, etc)_____

What vitamins do you currently take?_____ Other nutritional supplements_____

Do you smoke? ___Yes ___No How much per day?

How much alcohol do you consume on a weekly basis?_____

How much coffee, or caffeinated beverages do you consume on a daily basis?_____

Do you drink or eat "diet foods" with artificial sweeteners?_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I Understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Johnson Chiropractic Center insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services on my behalf or my dependents.

*X*_____

Signature of Patient (or Parent if a minor) *Date*