1 PATIENT INFORMATION

Date_____

Patient_____

Address _____

_____

City State Zip

Sex: ☐M ☐F Age ____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Number of Children _____

Patient SS# _____

Occupation_____

Employer _____

Employer Address _____

Employer Phone_____

Spouse's Name _____

Birthdate_____SS#_____

Occupation_____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co. _____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co. _____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Grover D. Johnson D.C. / Dr. Brad J. Johnson D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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

_____ _____

Relationship Date

3 PHONE NUMBERS

Home_____ Work _____ Ext ____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (If applicable) _____

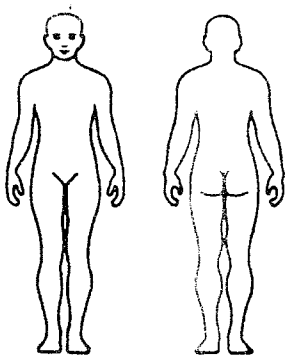
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear?_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Date last seen _____ ☐ Other _____

Name, phone and address of other doctor(s) who have treated you for your condition _____

_____

_____

Signature for release of chiropractic records to Family Dr. / Treating Dr. _____

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Other _____	
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No				
Diabetes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No				
Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No				

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS