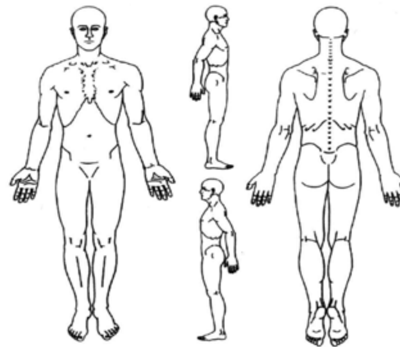
* Please provide your drivers license, insurance card, accident report, 3rd party insurance info, attorney info and any other literature pertaining to your case for photocopies.
* If you are seeking care due to an accident, it is possible care may be provided at no out of pocket cost to you.

TODAYS DATE:__________________________

Last Name:	First Name:	Middle Initial:
Address:	Apt #	City, State, Zip:
Home Phone:	Cell Phone:	Work Phone.:
Date of Birth:	Social Security #:	E-mail:
Occupation?: Work Name & Address:	Dominant Hand: ❑Right ❑Left ❑Both	
Married/Single/Divorced/Widowed Spouses Name:	Who may we thank for referring you?	
Primary Insurance Name: Who is responsible for your bill?: Deductible - $	Policy No.: Group No.: Chiropractic Coverage amounts -	

Please color in your areas of concern

❑HEAD/HEADACHES
❑SHOOTING / RADIATING / LIGHTENING
❑NUMBNESS
❑TINGLING / PINS& NEEDLES



-Your complaints are:
❑annoyance but no impairment ❑tolerable with some impairment ❑marked impairment ❑precludes activity

- Does pain affect your sleep? ❑Yes ❑No Keep awake or Wake you up?______________
- Have you ever had this before? ❑No ❑Yes, How long?______________________________
-Who else have you seen for this condition:

____

PAST HISTORY *DESCRIBE & YEAR*

- Surgeries:
- Trauma's:
- Illnesses:
- Medications and vitamins & amounts? Names and amounts:______________________________________

FAMILY HISTORY List all: Deceased, Living, Diabetes, High blood pressure, Cancer, Arthritis, Stroke, Heart

Mom: ❑Deceased ❑Diabetes ❑High blood pressure ❑Cancer ❑Arthritis ❑Stroke ❑Heart/Vessel disease

Dad: ❑Deceased ❑Diabetes ❑High blood pressure ❑Cancer ❑Arthritis ❑Stroke ❑Heart/Vessel disease

Siblings: ❑Deceased ❑Diabetes ❑High blood pressure ❑Cancer ❑Arthritis ❑Stroke ❑Heart/Vessel disease

Child1: Name:_______________ ❑Deceased ❑Any health condition:

Child 2: Name:_______________ ❑Deceased ❑Any health condition:

REVIEW OF SYSTEMS Check all symptoms that you are currently experiencing

Musculoskeletal: ❑Arthritis ❑Fractures/Dislocations ❑Sprains/strains ❑Diseases

Constitutional: ❑ High/Low Blood Pressure ❑Fever ❑Unexplained weight loss ❑Have a cold or flu

Skin: ❑Rashes ❑Lumps ❑Dry ❑Itching ❑Easy bruise ❑Color changes ❑Spots ❑ Other

Head: ❑Headache ❑Injury ❑Fainting ❑Dizzy ❑Seizures ❑Other

Eyes: ❑Pain ❑Injury ❑Visual problem ❑ Light sensitive ❑Blurred V. ❑Double V. ❑Spots ❑Excessive tears ❑Dry

Ears: ❑Pain ❑Itching ❑Excessive wax ❑Ringing ❑Hearing loss ❑Loss of balance ❑Discharges ❑Infections

Nose/Sinus: ❑Pain ❑Dryness ❑Bleeding ❑Congestion ❑Allergies ❑Frequent colds ❑Broken nose ❑Can't smell ❑Other

Jaw/Mouth/Throat: ❑Dentures ❑Pain ❑Swollen ❑Hoarseness ❑Gagging ❑Choking ❑Bleeding ❑Clicking ❑Swallow Problems

Lungs: ❑Chest pain ❑Short breath ❑Difficult breath ❑Breath odor ❑Cough ❑Phlegm ❑Night sweat ❑Chest noise ❑Other

Heart/Vessels: ❑High BP ❑Irregular Heart beat ❑Difficult breathing on exertion ❑Cold feet/hands ❑Skin color change ❑Swollen ankle/feet ❑Muscle pain on walking ❑Racing heart ❑Other

Abdomen: ❑Pain ❑Gas ❑Burning ❑Nausea ❑Vomiting ❑Yellowish eyes/skin ❑Appetite problems ❑Constipation ❑Diarrhea ❑Hemorrhoids ❑Other:

Neurologic: ❑Twitches ❑Shakes ❑Memory loss ❑Incoordination ❑Loss of strength ❑Numbness/Tingling

Urinary: ❑Painful urine ❑Difficult urine ❑Change urine frequency ❑Night urination ❑Blood in urine ❑Bleeding/ Spotting ❑Prostate problem ❑Venereal disease ❑Other:

Psychiatric: ❑Depression ❑Bipolar disorders ❑Confusion ❑Hallucinations ❑Dementia ❑Retardation

Immune: ❑HIV/AIDS ❑Rheumatoid disorders ❑Other immune disorders

Menstrual: Date of last OB/GYN: _________First period Age __________ Last period date _____ ❑Irregularity ❑Excessive Cramps ❑Spotting between periods ❑Discharges ❑Difficult pregnancies ❑Breast dimpling ❑Nipple inversion ❑Abortions ❑Lost pregnancies ❑Trying to get pregnant ❑Any chance you are pregnant? ❑Yes ❑No

Job Position____

Does your job involve: ❑ Sitting ❑Standing ❑Lifting How much do you lift consistently? ______lbs ❑Bending ❑Twisting ❑Talking on phone ❑Computer work ❑Other:

Has your occupation contributed to your current condition? ❑YES ❑NO

SOCIAL HISTORY

Married? ❑Yes ❑No Highest educational degree obtained?______________________

Drug use? ❑Yes ❑No ______ Alcohol use? ❑Yes ❑No_______ Tobacco use? ❑Yes ❑No__________

Sleep habits? Hrs/night? ________ How? ❑Right side ❑Left side ❑Stomach ❑Back

Ever been exposed to Poisons/Toxins at home, work, or other? ❑Yes ❑No

Exercise/Recreational activities? ❑Yes ❑No What type and how often:

LIST THE GOALS YOU WANT FROM CHIROPRACTIC CARE

1. ______________________ 3. ______________________ 5. ___________________
2. ______________________ 4. ______________________

PLEASE RATE THE FOLLOWING FOR YOU **like this…** |_______|_______|

No Energy |______________________________________| **Abundant Energy**

No Pain |______________________________________| **Intolerable Pain**

Slumped Posture |______________________________________| **Perfect Posture**

Negative Attitude |______________________________________| **Positive Attitude**

Young Body Age |______________________________________| **Old Beyond Your Years**

Out of Shape |______________________________________| **Peak Physical Shape**

Glass Half Empty |______________________________________| **Glass Half Full**

BETTER HEALTH THROUGH CHIROPRACTIC 602-992-2060

PLEASE READ*: We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE <u>ONE</u> CHOICE WHICH DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain C/L

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing,Dressing,etc.) C/L

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting C/L

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C I can only lift heavy weights if they are conveniently positioned
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 – Reading C

A I can read as much as I want to with no pain.
B I can read as much as I want to with slight pain.
C I can read as much as I want to with moderate pain.
D I cannot read as much as I want because of moderate pain.
E I cannot read as much as I want because of severe pain.
F I cannot read at all.

SECTION 5 – Headaches C

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 – Concentration C

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 – Work C/L

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 – Driving C/L

A I can drive my car without any pain.
B I can drive my car as long as I want with slight pain
C I can drive my car as long as I want with moderate pain.
D I cannot drive my car as long as I want because of moderate pain
E I can hardly drive at all because of severe pain.
F I cannot drive my car at all.

SECTION 9 – Sleeping C/L

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 – Recreation C/L

A I am able to engage in all of my recreational activities with no pain at all.
B I am able to engage in all of my recreational activities with some pain.
C I am able to engage in most, but not all of my recreational activities because of pain.
D I am able to engage in a few of my recreational activities because of pain.
E I can hardly do any recreational activities because of pain.
F I cannot do any recreational activities at all.

SECTION 11 – Standing L

A I can stand as long as I want without extra pain.
B. I can stand as long as I want but it gives me extra pain.
C. Pain prevents me from standing for more than 1 hour.
D. Pain prevents me from standing for more than 30 minutes.
E. Pain prevents me from standing for more than 10 minutes.
F. Pain prevents me from standing at all.

SECTION 12 – Walking L

A. Pain does not prevent me walking any distance.
B. Pain prevents me walking more than 1 mile.
C. Pain prevents me walking more than ½ mile.
D. Pain prevents me walking more than ¼ mile.
E. I can only walk using a cane or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 13 – Sitting L

A. I can sit in any chair as long as I like.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me sitting more than 1 hour.
D. Pain prevents me from sitting more than a ½ hour.
E. Pain prevents me from sitting more than 10 minutes.
F. Pain prevents me from sitting at all.

Date_______________NeckADL_________LowbackADL________

INTRODUCTION

The profession of chiropractic, dentistry, medicine and surgery, nursing, optometry, osteopathy, osteopathic medicine and surgery, pharmacy, physical therapy, podiatry, psychology, and other health professions are regulated by the state. Patient care provided by these health professions, including chiropractic, have known risks which are incredibly rare, but may include death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such health care professions and treatment. For your information, the following is routinely furnished to all who consider chiropractic care in this clinic.

The office of Dr. Scott M. Johnson, Chiropractor is an office offering chiropractic services and is registered or licensed with the U.S., state, and local government. Chiropractic is a science that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) of the body as the relationship of the two may effect the restoration and preservation of health.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentations, laboratory tests, radiology examinations, physical therapy and related rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession – the chiropractic spinal adjustment.

Adjustments are made by chiropractors to correct spinal and extremity joint subluxation. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. **The primary goal in chiropractic health care is the removal of nerve interference caused by subluxation(s). We do not treat symptoms or diseases, as this is the practice of medicine. We locate and correct subluxations in the body for the purpose of reducing nerve interference. Doing so opens the channels to allow the body to begin restoring homeostasis or functional balance.**

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of a vertebra or other bone.

Not only should you understand the benefits of chiropractic care in restoring and maintaining health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risk associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome (VAS), including stroke and perhaps, death through complicating factors. There are tests and screenings done at Better Health Through Chiropractic that will alert the doctor of predispositions toward these risks. Though steps are taken to minimize the risk, the risk is still there to some degree

INITIALS_________

AUTHORIZATION FOR CHIROPRACTIC CARE

I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risks of the care, including the risk, that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I understand that insurance benefits, eligibility and pre-certification information is based on information I provide and specific questions asked and is not a guarantee of coverage or payment. I understand that a guarantee of coverage and benefits can only be obtained once the insurance company sends response to the submitted claim. I also agree to pay all charges and/or co-payments at the time of service. I hereby authorize and assign payment from the insurance I wish to use, directly to Scott M. Johnson, D.C. and BHTC for professional services rendered. I herby authorize the attending doctor to release any and all information concerning my examination or statement for purposes of satisfying these bills. If, before, during, or after the time of treatment in this office, your insurance coverage is found to be less than at first believed or nonexistent, then I understand that I am responsible for payment in full of any unpaid services and fees. I understand that should, by any reason or inadvertency, any payment of check come directly to me from these insurance(s), that I am not entitled to keep said check, but should pay it directly to *Better Health Through Chiropractic* within 10 days of receipt or incur a 10% fee every month of delinquency. If this account should go into default I understand that I will be held liable for all reasonable collection fees and attorney fees incurred to collect this debt. In addition, I understand and accept that *Better Health Through Chiropractic* does not reduce bills, remove performed services from bills, or write-off portions of bills especially for the purpose of conforming to fit within an insurance settlement, payment, or attorney disbursement. I further understand and accept that I am liable for any outstanding balance after an insurance or attorney disbursement.
This, or a photocopy, will also serve as an authorization for release of emergency department, urgent care and/or medical records which may be necessary in my medical care or any insurance company with which I have a contractual agreement.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS THAT I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE SCOTT M. JOHNSON, D. C. TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

____

(PRINT NAME)

____

(PATIENTS SIGNATURE AND DATE)

WHEN A PATIENT IS A MINOR OR UNABLE TO CONSENT:

Patient is a minor_______ years of age, or other
Person authorized to sign for the patient,
Print name and relationship: ________________________________

Signature of authorized person:______________________________

C-C START TIME: