Johnson Chiropractic Clinic

Edward T. Johnson, D.C * 600 East John Sims Parkway, Niceville, Florida 32578
850-729-8050 * Fax: 850-729-0050

PATIENT INFORMATION

Date: ______________

(Mr. Mrs. Ms.) First Name: ______________________________ MI: ____ Last Name: ____________________________
Scheduling Name (if you go by another name/nickname): ____
Address: ____ City: __________________ State: ____ Zip Code: __________
Home Number: ____________________ Work Number: ____________________ Cell Number: ______________
E-Mail: ____ Sex: Male ______ Female ______
Occupation: __________________________ SSN: ______________________ Date of Birth: ______________
Driver's License #: ____ State: ______________

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Minor

Spouse:
(Mr. Mrs. Ms.) First Name: ______________________________ MI: ____ Last Name: ____________________________
SSN: ____________________________________ Date of Birth: ____________________
Spouse Employer Name: ____ Spouse Number: ______________
Occupation: ____
Patient's Employer Name: ____
Address: ____ City: __________________ State: ____ Zip Code: __________

Emergency Contact: (not living in the home)
Name: ____ Phone Number: ____________________

Referred:
(Mr. Mrs. Ms.) Name: ____
Address: ____ City: __________________ State: ______ Zip Code: __________

Insurance:
Who is responsible for this account? ____
Relationship to Patient: ____________________________ Insurance Company: ____________________________
ID#: ______________________________ Group #: ______________________________
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name: ____
Birth Date: ______________ SSN: ______________________
Relationship to Patient: ______________________
Insurance Co. ____ Group# ____________________________

ASSIGNMENT AND RELEASE

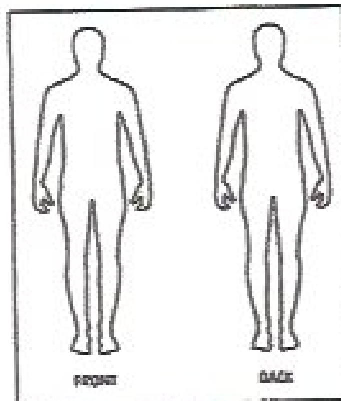
I certify that I, and/ or my dependent(s), have insurance coverage with ____________________________ and assign directly to *Dr. Johnson* all insurance benefits, Name of Insurance Company (ies) if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________________ ______________________
Date Relationship of Patient

PATIENT CONDITION



Reason for visit ______________________

When did your symptoms appear? ______________________

Is this condition getting progressively worse? ______________________

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

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) ________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numb ☐ Aching

☐ Shooting ☐ Tingling ☐ Stiff ☐ Cramping ☐ Burning ☐ Sharp

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

Are your present problems due to an injury? ☐ No ☐ Yes ☐ On the Job ☐ Auto Accident ☐ Personal Injury

If yes, have you made a report of your accident? ☐ No ☐ Yes ☐ To Employer ☐ Auto Carrier ☐ Other

Has the accident been reported? ☐ No ☐ Yes ☐ Work. Comp ☐ Auto Carrier ☐ Other

Are you now or have you ever been disabled? (Service or Work?) ☐ No ☐ Yes When ______________________

Have you retained an attorney? ☐ No ☐ Yes Name & Address ______________________

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

☐ Chiropractic Services ☐ Massage Therapy ☐ None ☐ Other

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

____

List any accidents or falls and dates: ☐ Car ____________ ☐ Recreational Vehicle ____________

☐ School ____________ ☐ Sports ____________ ☐ Other ____________

List any broken bones, fractures or dislocations: ______________________

____

____

Have you ever been on crutches? ☐ No ☐ Yes Why? ______________________

Have you ever had spinal taps or injections? ☐ No ☐ Yes Were you ever knocked unconscious? ☐ No ☐ Yes

Have you ever had a lapse of memory? ☐ No ☐ Yes

Have you ever had X-rays taken? ☐ No ☐ Yes When? ____________ By Whom? ____________

For what ailments were these X-rays taken? ______________________

____

Do you suffer from any other condition other than that for which you are consulting us? ______________________

____

Please list any medications (prescription or over-the-counter) or supplements you may be taking: ______________________

____

____

Please be as thorough as possible in answering the following questions.

Operations & Procedures:

(please give the most current date)

- Spinal exam ____________
- Disc exam ____________
- X-ray exam ____________
- Lab exam ____________
- Last Physical ____________
- Pap smear ____________
- Breast exam ____________
- Vaccinations ____________
- Tonsillectomy ____________
- Gall Bladder ____________
- Back Operation ____________
- Tubes in Ears ____________
- Appendectomy ____________
- Sinus surgery ____________
- Hernia ____________
- Knee surgery ____________
- Rotator Cuff ____________
- Thyroid ____________
- Stomach ____________

Have You Had The Following?

- _____ Appendicitis
- _____ Pneumonia
- _____ Rheumatic Fever
- _____ Polio
- _____ Tuberculosis
- _____ Whooping Cough
- _____ Anemia
- _____ Measles
- _____ Mumps
- _____ Chicken Pox
- _____ Diabetes
- _____ Cancer
- _____ Heart Disease
- _____ Goiter
- _____ Influenza
- _____ Pleurisy
- _____ Alcoholism
- _____ Arthritis
- _____ Epilepsy
- _____ Mental Disorder
- _____ Lumbago
- _____ AIDS/HIV

FAMILY HISTORY:

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐

HABITS:

- ☐ Smoking — Packs/Day ____________
- ☐ Alcohol — Frequency ____________
- ☐ Caffeine — Cups/Day ____________
- ☐ Stress — Frequency ____________

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Please enter "P" for Previously and "C" for Currently in front of all of the following sings and symptoms. Leave blank if not applicable to you. A complete history and understanding of your health will help facilitate your care.

GENERAL SYMPTOMS

- _____ Headaches
- _____ Fever
- _____ Chills
- _____ Night Sweats
- _____ Fainting
- _____ Dizziness
- _____ Convulsions
- _____ Loss of Sleep
- _____ Fatigue
- _____ Nervousness
- _____ Weight Loss
- _____ Numbness or pain in arms/legs/hands
- _____ Allergy (to what)
- _____ Wheezing
- _____ Neuralgia

GASTRO-INTESTINAL

- _____ Poor Appetite
- _____ Poor Digestion
- _____ Excessive Hunger
- _____ Belching or Gas
- _____ Nausea
- _____ Vomiting
- _____ Vomiting Blood
- _____ Pain over Stomach
- _____ Constipation
- _____ Diarrhea
- _____ Colon Trouble
- _____ Hemorrhoids (Piles)
- _____ Liver trouble
- _____ Jaundice
- _____ Gall Bladder trouble

EYE/EAR/NOSE/THROAT

- _____ Poor Vision
- _____ Crossed Eyes
- _____ Pain in Eyes
- _____ Deafness
- _____ Earache
- _____ Ear Noises
- _____ Discharge from Ear
- _____ Nasal Obstruction
- _____ Nose Bleeds
- _____ Sore Throats
- _____ Hoarseness
- _____ Hay Fever
- _____ Asthma
- _____ Frequent Colds
- _____ Enlarged Thyroid
- _____ Tonsillitis
- _____ Sinus Trouble

RESPIRATORY

- _____ Chronic Cough
- _____ Spitting Blood
- _____ Spitting Phlegm
- _____ Chest Pain
- _____ Difficulty Breathing

GENITO-URINARY

- _____ Frequent Urination
- _____ Painful Urination
- _____ Blood in Urine
- _____ Kidney Infection
- _____ Bed Wetting
- _____ Inability to Control Urine
- _____ Prostate Trouble

MUSCLES AND JOINTS

- _____ Weakness
- _____ Twitching
- _____ Stiff Neck
- _____ Backache
- _____ Swollen Joints
- _____ Tremors
- _____ Foot Trouble
- _____ Painful Tail Bone
- _____ Pain Between Shoulders
- _____ Hernia
- _____ Spinal Curvature

CARDIO-VASCULAR

- _____ Rapid Heartbeat
- _____ Slow Heartbeat
- _____ High Blood Pressure
- _____ Low Blood Pressure
- _____ Pain Over Heart
- _____ Heart Trouble
- _____ Swelling in Ankles
- _____ Poor Circulation
- _____ Varicose Veins
- _____ Strokes

SKIN OR ALLERGIES

- _____ Skin Eruptions
- _____ Itching
- _____ Bruising Easily
- _____ Dryness
- _____ Boils
- _____ Sensitive Skin
- _____ Hives or Allergy
- _____ Eczema
- _____ Medicines (list)

____

____

____

FOR WOMEN ONLY

- _____ Painful Periods
- _____ Excessive Flow
- _____ Irregular Cycle
- _____ Hot Flashes
- _____ Cramps/Backaches
- _____ Miscarriage
- _____ Vaginal Discharge
- _____ Pregnant at this time
- _____ Last Pap

By Whom____________

____

Other

____

____

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

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.)

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

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
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

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

SECTION 5 - Headaches

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

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

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

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

SECTION 9 - Sleeping

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

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

COMMENTS: ______________________________

NAME: ______________________ DATE: __________ SCORE: __________

THE REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

DATE: ______________

PATIENT NAME: ________________________________

Please read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 - Personal Care

A I do not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain I am unable to do some washing and dressing without help.
F Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights at the most.

SECTION 4 - Walking

A I have no pain on walking.
B I have some pain on walking but it does not increase with distance.
C I cannot walk more than one mile without increasing pain.
D I cannot walk more than 1/2 mile without increasing pain.
E I cannot walk more than 1/4 mile without increasing pain.
F I cannot walk at all without increasing pain

SECTION 5 - Sitting

A I can sit in any chair as long as I like.
B I can sit only in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than 10 minutes.
F I avoid sitting because it increases pain straight away.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B I have some pain on standing but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than 10 minutes without increasing pain.
F I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get pain in bed but it does not prevent me from sleeping well.
C Because of pain my normal night's sleep is reduced by less than 1/4.
D Because of pain my normal night's sleep is reduced by less than 1/2.
E Because of pain, my normal night's sleep is reduced by less than 3/4.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A My social life is normal and gives me no pain.
B My social life is normal but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life, and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 - Travel

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling, which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing degree of pain

A My pain is rapidly getting better.
B My pain fluctuates but overall is definitely getting better.
C My pain seems to be getting better but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

SIGNATURE: ________________________________

Johnson Chiropractic Clinic
600 East John Sims Parkway
Niceville, Florida 32578
850-729-8050 *850-729-0050*

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

______________________________ ______________

Patient Name (please print) Date

____

Please Print of Guardian or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Johnson Chiropractic Clinic

Edward Johnson, B.A.,M.S., D.C.
600 East John Sims Parkway
Niceville, Florida 32578
850-678-1795 *850-729-0050*

Patient's Name:______________________________ D.O.B.:__________

Address: ____

City____________________ State:______________ Zip Code:__________

SSN:______________________ Home Number:______________________

Mailing Address (if different)__________________________________

City: ______________________ State:________ Zip Code:__________

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL INFORMATION

To Whom It May Concern:

I hereby authorize the office of Edward Johnson, B.A.,M.S., D.C. to request any medical records, x-rays, emergency room reports, physician's reports, police reports, and/or other pertinent information pertaining to my care. I also authorize the office of Edward Johnson, B.A.,M.S., D.C. to release or furnish to any requesting hospital, physician, or other attending medical professional, insurance company, or attorney(with appropriate signed release, any specifically requested medical information, including x-rays, pertaining to my case.

______________ **(Patient's initials)**

PATIENT FINANCIAL POLICY

- All payments for services are due on the date of receipt of service.
- Patients are ultimately responsible for payment of their account, regardless of any third party payer (insurance coverage)
- Patients with outstanding balance will make arrangements for installment payments.
- Patients are responsible for informing this office if there is any change in insurance coverage.
- Patients are responsible for informing this office if there is any change in personal information (including address, telephone, etc)
- All patients are to notify our office 24 hours in advance if you are unable to keep your appointment. Failure to do so may at the Doctors discretion be processed as a **NO SHOW.** $45.00 will be charged to the account for each appointment not properly cancelled. This fee is not covered by insurance and will be the responsibility of the patient. ______________ **(Patient's initials)**

Patient Name: ___

May we phone, email, or send a text to you to coniform appointments? YES NO

May we leave a message on your machine at home or on your cell phone? YES NO

May we discuss your medical condition with member of your family? YES NO

If YES, please specify the members with whom we may discuss your information.

Name	Phone Number	Relationship

INFORMED CONSENT FOR TREATMENT

I hereby certify that I have read and understand the contents of this form, and I have signed this document knowingly, freely and voluntarily. Moreover, I certify and state that I have received no assurances or guarantees from anyone as to the results that may be obtained by any treatment or services.

___ Patient/Parent/Guardian ___ Date

___ Witness ___ Date

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, and law enforcement activities. Any other disclosers for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee photocopying, postage, and preparation.

You may request corrections to your records. My practice has the right to accept or deny your request.

I maintain a history of protected health information disclosures that is accessible to you.

In the future, I may contact you for appointment reminders, announcements, and to inform you about my practice and staff.