Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing | City | State | Zip Code

Home Telephone ( ) _____ Work Phone ( ) _____ Male____ Female____

Social Security # _____ Driver's Lic.# _____ Birthdate _____

Occupation/Employer's Name and address _____

Single____ Married____ Divorced____ Widowed____ Spouse's Occupation/Employer _____

No. of children:____ (In Canada) Health Card#_____ Version Code: _____

Reason for consulting our office?_____

Who may we Thank for referring you to our office?_____

Your Health Profile

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take / use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

COMMENTS: _____

_____

Adult - (18 to present)

	YES	NO
Do / did you smoke?	☐	☐
Do / did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do / did you play any adult sports?	☐	☐
Do /did you participate in extreme sports?	☐	☐

On a scale of 1 - 10 describe your stress level:
(1 = none / 10 = Extreme)
Occupational _____
Personal _____

On a scale of Poor, Good, Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here ____ "**Wish to have Chiropractic Wellness Services**" and skip to "**Family Health Profile**." Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it...

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is... ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: _____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

☐ Chiropractor _____

☐ Medical Doctor _____

☐ Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold Hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking _____

_____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

Have you ever:

Bought bottled water: ☐ **YES** ☐ **NO**

Belonged to a health club: ☐ **YES** ☐ **NO**

Consumed vitamins or supplements: ☐ **YES** ☐ **NO**

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

_____ _____

Signature Date

PAIN DIAGRAM

PATIENT NAME:_____ **DATE**_____

Subluxation may cause any of the following which do you have today?

A= ache	N = numbness
B = burning	P = pain
C= cramping	S = spasm
T = tingling	

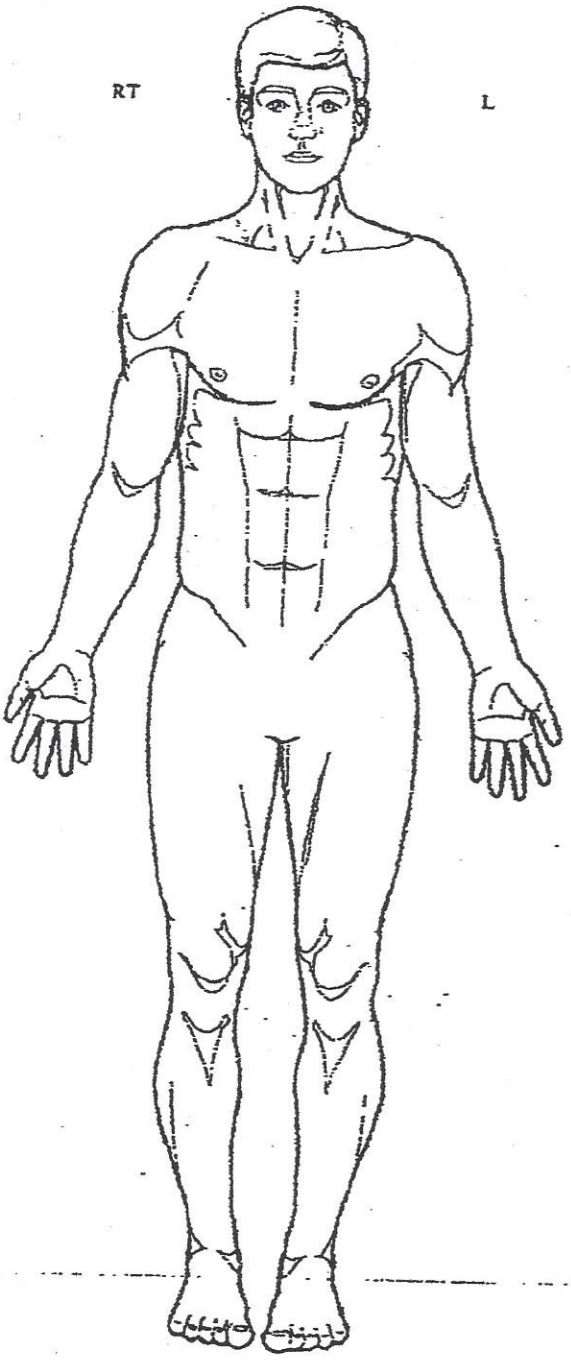
1. Color in the diagram where your symptom occurs
2. Label the symptom with the appropriate letter
3. Assign a number 0 to 10

0 = no pain and 10 = extreme pain

Patient Signature _____

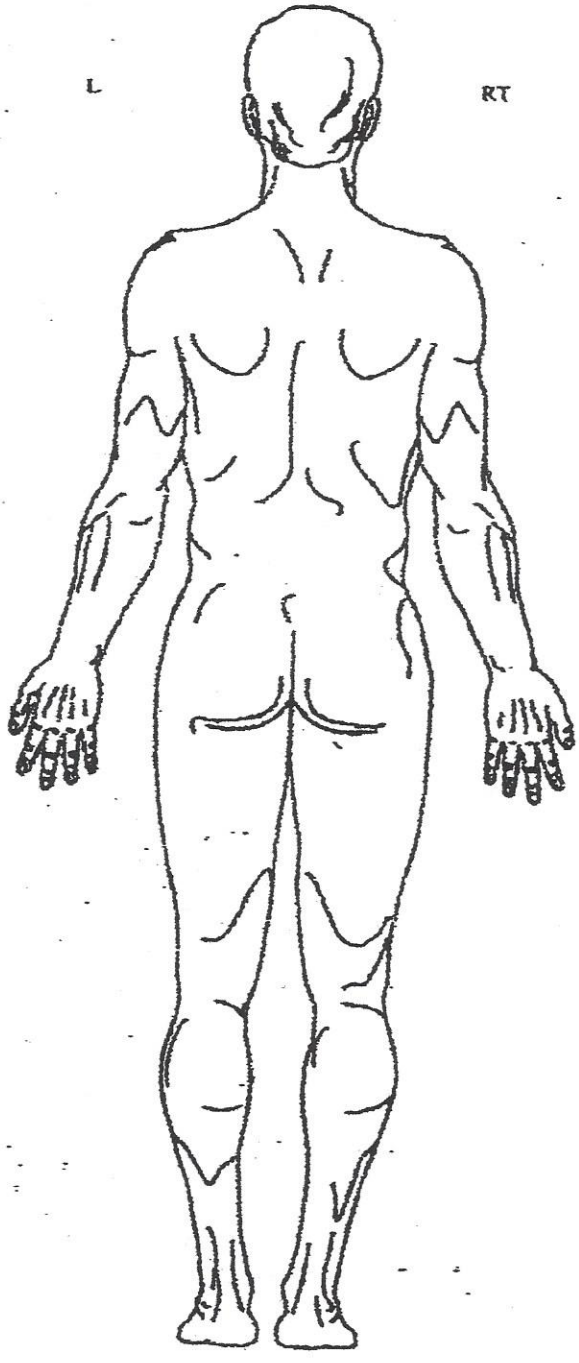
FRONT

RT L



BACK

L RT



JOHNSON CHIROPRACTIC

108 S. Main * Crandall, Texas 75114
972) 472-3818 Phone * 972) 472-3819 Fax

CONSENT TO TREATMENT

PATIENT'S NAME:_____ DATE:_____

I hereby authorize the staff of Johnson Chiropractic to provide treatment for myself, including **CHIROPRACTIC ADJUSTMENTS, X-RAYS, DIAGNOSTIC TESTING, PHYSICAL THERAPY, NUTRIONAL THERAPY, REHABILITATION, MASSAGE THERAPY,** and other services as are deemed necessary. If the patient is a minor, I certify that I am the legal guardian and that I grant permission for care of the patient.

Signed:_____

Parent or Guardian:_____ Relationship:_____

Witnessed by:_____

Translated by:_____

PREGNANCY RELEASE

I certify that I am not pregnant. I hereby release Johnson Chiropractic and its staff from any and all liability.

Signed:_____

Witnessed by:_____

Translated by:_____

JOHNSON CHIROPRACTIC

108 S. Main; P.O. Box 831 * Crandall, Texas 75114
972) 472-3818 * 972) 472-3819 Fax

Patient Name: _____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize and direct that payment be made directly to:

Johnson Chiropractic
George G. Johnson, D.C.
108 S. Main; P.O. Box 831
Crandall, Texas 75114

for any and all insurance benefits or reimbursements for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

Release of Information. I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare.

Payment Agreement. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits, or failure to pay for any reason, I understand that I am responsible for all remaining charges.

_____ _____

Patient Signature Date

JOHNSON CHIROPRACTIC

108 S. Main * Crandall, Texas 75114
972) 472-3818 * 972) 472-3819 Fax

CONSENT TO CHARGE CREDIT/DEBIT CARD

I do hereby give Johnson Chiropractic (George Gary Johnson, D.C.) my consent to charge the following credit/debit card account for any future services rendered at the location listed above; and understand that these transactions will be billed/charged through the primary office location of: 108 S. Main, P.O. Box 831 Crandall, Texas 75114.

Account # _____

Expiration Date _____

CVC: _____

Printed Name: _____

Signature: _____

Date: _____