# JOHNSTONE CHIROPRACTIC

Dr Jeremy S. Johnstone DC
515 SR 9 NE, Suite 105, Lake Stevens, WA 98258

Chart # ____________

## ✵ Welcome ✵

### PATIENT INFORMATION

Date ____________

Name ____________________________

Mailing Address ____________________________

____________________________

Home Phone ____________ Cell ____________

Sex M F Age ______ Birth Date ____________

Single / Married / Divorced / Seperated / Widowed

Employer ____________________________

Full Time / Part Time / Retired / Unemployed

Work Phone ____________ Ext ______

### Spouse / Parent Information

Name ____________________________

Employer ____________________________

Work Phone ____________ Ext ______

### Emergency contact person

____________________ ____________
Name Relationship

Home Phone ____________________

Work Phone ____________ Ext ______

### PATIENT CONDITION

Reason for visit ____________________________

____________________________

When did condition begin? ____________________

Has this condition gotten worse stayed the same
comes and goes

Has this condition occurred before? Yes No

Other doctors seen for this condition? Yes No

Dr.'s Name ____________________

Date of last x-ray ____________

Is condition related to an accident? Yes No

Date of accident ____________

Type of accident Auto Work Home Other

If job related, have you reported the accident to your employer? Yes No

Do you have an attorney? Yes No

Attorney Name ____________________

Attorney Phone # ____________________

Who referred you to our office? ____________

Have you been to a Chiropractor before? Yes No

### INSURANCE INFORMATION

**Primary Insurance** ____________________

Insurance ID # ____________________

Insurance Phone # ____________________

Group # ____________________

Name of Insured ____________________

Insured Birth Date ____________ Relationship ____________

Address of Insured ____________________

____________________________

**Secondary Insurance** ____________________

Insurance ID # ____________________

Insurance Phone # ____________________

Group # ____________________

Name of Insured ____________________

Insured Birth Date ____________ Relationship ____________

Address of Insured ____________________

____________________________

### Auto Accident Insurance Information

Your Auto Insurance Co ____________________

Your Auto Insurance Co Phone # ____________________

Do you have PIP coverage? Yes No

PIP Insurance Claim # ____________________

At Fault Insurance Co ____________________

At fault Insurance Co Phone # ____________________

Insurance Claim # ____________________

I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payments of the insurance benefits. I authorize the use of this signature on all insurance submissions.

____________________________
Signature of Responsible Party

Relationship ____________ Date ____________

## HEALTH CONDITIONS

Please check each of the conditions or diseases that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ☐ Severe or frequent headaches
- ☐ Sinus problems
- ☐ Dizziness
- ☐ Loss of Sleep
- ☐ Pain between the shoulders
- ☐ Frequent Neck Pain
- ☐ Numbness or Pain in Arms, Hands, or Legs
- ☐ Lower Back Problems
- ☐ Digestive Problems
- ☐ Difficulty Breathing
- ☐ Heart Attack ☐ Stroke (Date: _____ )
- ☐ Heart Murmur
- ☐ Heart Surgery (Date: _____ ) ☐ Pacemaker
- ☐ Asthma
- ☐ Arthritis
- ☐ Anemia
- ☐ Cancer (please specify: ____________)
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Ulcer ☐ Colitis
- ☐ Kidney Problems
- ☐ Thyroid Problems
- ☐ Psychiatric Problems
- ☐ Congenital Heart Defect
- ☐ High ☐ Low Blood Pressure

## HEALTH HABITS

(Please circle)

| | |
|---|---|
| Tobacco use: | yes / no |
| Alcohol consumption: | yes / no |
| Coffee consumption: | yes / no |
| Exercise regularly: | yes / no |

## WOMEN

| | |
|---|---|
| Pregnant: | yes / no |
| Nursing: | yes / no |
| Taking birth control: | yes / no |
| Irregular menstrual cycles: | yes / no |
| Painful menstrual cycles: | yes / no |

## MEDICATIONS

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

I hearby authorize the doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred on my behalf at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hearby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

______________________________ ______________________________

Patient Signature Date Parent/Guardian/Spouse Signature Date

JOHNSTONE CHIROPRACTIC
Office (425) 334-1874 Dr. Jeremy S. Johnstone DC Fax (425) 334-3852

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method or correction is by specific adjustments of the spine.

**Health:** A state of optimal physical, mental, and social well being, not merely the absence of infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____________________________ have read and fully understand the above statements.
(Please print your name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____________________________ ____________________
(Signature) (Date)

**Consent to evaluate and adjust a minor child**

I, ____________________________ being the parent or legal guardian of ________________________ have fully read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Pregnancy Release**
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: ________________

____________________________ ____________________
(Signature) (Date)

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