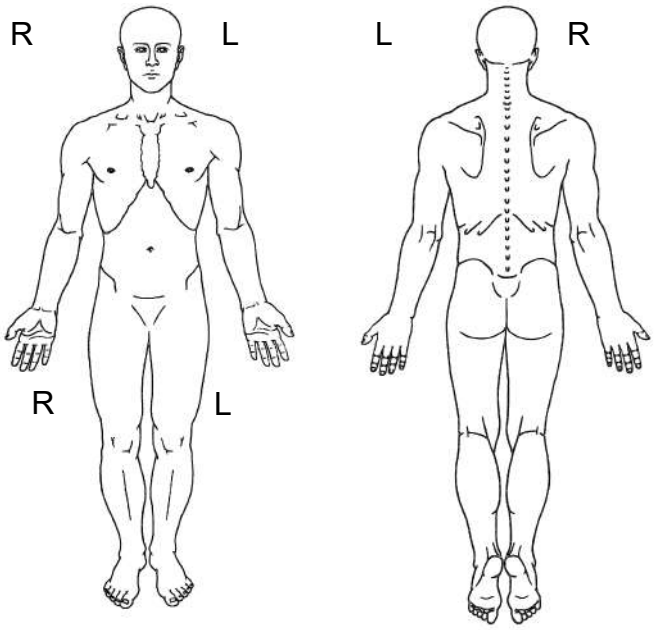
PATIENT HISTORY PERSONAL INJURY

Name _____ Date _____

Place the letters on the figure below to indicate the type and location
of your present sensations.

A= ache **B**= burning **N**= numbness
P= Pins & needles **S**= stabbing **O**= other



Please place a mark on the line below indicating your present level of pain.

0 10
mild moderate severe

No Pain Worst Pain Imaginable

If you have multiple area of symptoms instead of using the 1-10 scale above when you mark each area on the figure to the left, include a # on the 1-10 scale and a about what % of your waking hours you experience the Symptom for each area or body part.

How often are your complaints present :

0-25% **26-50%** **51-75-%** **76-100%**

Please describe your major complaint with regards to the **type** your pain. For example: dull, sharp, soreness, stiffness, throbbing, shooting, burning, spasm, weakness.

_____

_____

_____

Date of Accident _____ Time_____
Please describe the accident in your own words: _____
_____
Please describe how you felt: during the accident. _____
Immediately after the accident _____
Were you: Dazed Dizzy Unconscious In Shock Shaky Light-headed Nervous Stunned Confused Nauseated
How did you feel later that day? _____
Were you able to sleep that night? yes no if no, describe _____
Was your sleep altered or disturbed? yes no if yes, describe _____
How did you feel the next day? _____
How did you feel a week later? _____
Since this injury occurred, are your symptoms? improving getting worse staying the same
Has the condition altered your ability to sleep? yes no If yes, describe _____
_____
Has the condition altered your ability to interact with family/friends? yes no If yes, describe _____
_____
Has the condition altered your ability to care for yourself? yes no If yes, describe _____
_____
Has the condition altered your ability to function at work? yes no If yes, describe _____
_____
Have you taken time off work as a result of this injury? yes no If yes, when did you last work? _____
If you are working now, are you in discomfort? yes no If yes, describe _____
_____

Doctor's Notes

_____

_____

PAST OR PRESENT SYMPTOMS
If you had any of the symptoms below before your current injury put a check under "past"
for any symptoms that started since the injury check under "present"

past present **HEAD**
[ ] [ ] Headaches
[ ] [ ] Dizziness
[ ] [ ] Tension
[ ] [ ] Fainting
[ ] [ ] Tired, Fatigue
[ ] [ ] Head feels heavy
[ ] [ ] Light bothers eyes
[ ] [ ] Loss of taste or smell

NECK
[ ] [ ] Neck pain
[ ] [ ] Neck stiffness
[ ] [ ] Neck spasms
[ ] [ ] Popping in neck

SHOULDER
[ ] [ ] Pain in shoulder jt
[ ] [ ] Tension in shoulders

ARM&HAND
[ ] [ ] Arm pain (R-L)
[ ] [ ] Arm numbness (R-L)
[ ] [ ] Wrist/hand pain (R-L)
[ ] [ ] Weak grip (R-L)
[ ] [ ] Elbow pain (R-L)
[ ] [ ] Cold hands

past present **MID-BACK**
[ ] [ ] Upper back pain
[ ] [ ] Pain between shlders
[ ] [ ] Rib pain

CHEST
[ ] [ ] Chest pain
[ ] [ ] Shortness of breath
[ ] [ ] Breast pain

ABDOMEN
[ ] [ ] Heartburn
[ ] [ ] Stomach cramps
[ ] [ ] Nervous stomach
[ ] [ ] Food allergies _____
[ ] [ ] Gas
[ ] [ ] Constipation
[ ] [ ] Diarrhea
[ ] [ ] Nausea
[ ] [ ] Vomiting
[ ] [ ] Blood in stool
[ ] [ ] Hepatitis

FAMILY HISTORY
[ ] [ ] Cancer
[ ] [ ] Diabetes
[ ] [ ] Heart Disease
[ ] [ ] Arthritis

past present **LOWER BACK**
[ ] [ ] Lower back pain
[ ] [ ] Buttock pain
[ ] [ ] Muscle spasms
[ ] [ ] Lower back stiffness
[ ] [ ] Back feels tired
[ ] [ ] Pain increased by coughing

HIP, LEG&FOOT
[ ] [ ] Hip pain (R-L)
[ ] [ ] Pain in leg (R-L)
[ ] [ ] Knee pain (R-L)
[ ] [ ] Knee gives way (R-L)
[ ] [ ] Leg cramps
[ ] [ ] Shooting pain in leg/foot (R-L)
[ ] [ ] Tingling in leg/foot (R-L)
[ ] [ ] Numbness in leg/foot (R-L)
[ ] [ ] Swollen ankles
[ ] [ ] Ankle/Foot pain (R-L)
[ ] [ ] Ankle sprain (R-L)

MISC.
[ ] [ ] Loss of bowel or bladder control
[ ] [ ] Loss of memory
[ ] [ ] Fever
[ ] [ ] Cancer

past present **WOMEN ONLY**
[ ] [ ] Menstrual pain
[ ] [ ] Cramping
[ ] [ ] Irregular cycle
[ ] [ ] Birth control _____type
[ ] [ ] Hysterectomy
[ ] [ ] Cesarean delivery

MEN ONLY
[ ] [ ] Urinary frequency
[ ] [ ] Difficulty starting urination
[ ] [ ] Painful urination

GENERAL
[ ] [ ] Nervousness
[ ] [ ] Irritable
[ ] [ ] Depression
[ ] [ ] Fatigue
[ ] [ ] Loss of sleep___hrs./night
[ ] [ ] Loss of weight ___lbs.
[ ] [ ] Gain of weight ___lbs.
[ ] [ ] Coffee ___cups/day Tea ___cups/day
[ ] [ ] Alcohol ___ drinks per week
[ ] [ ] Pain worse at night or at rest

COLLISION CONDITIONS

What was your position in the car? driver front passenger rear seat: L R Middle 3rd row seat L R Middle other _____

How many people were in the car including yourself? _____ Was anyone else injured? _____

What were the road conditions? dry wet icy Weather conditions ? clear fog rain snow glare

Were you wearing a seat belt? yes no If yes, what type? lap only lap & shoulder

Did your seat have a headrest? movable headrest non movable headrest no headrest don't remember
How was your headrest positioned? at top of back of head middle of back of head bottom of back of head at neck

Is your car equipped with? ABS Airbags If you have airbags did they inflate? Yes No Were you injured by the airbags? Yes No

Model, year and make of your vehicle? _____ Other Vehicle? _____

What is the estimated damage to your vehicle? _____ To other vehicle? _____

Did you take any photos at the scene? yes no Any photos of damage to your vehicle? yes no
Any photos of damage to other vehicles? yes no

Doctor Notes:

_____

_____

_____

POINT OF IMPACT

Was the impact a? single car crash two vehicle crash three or more ran off road hit guardrail/tree other _____

rear ended head on crash sideswiped L R T-bone L R struck another car from behind

Did your vehicle strike another vehicle ? yes no Did your vehicle strike anything else? Describe _____

Was your vehicle? speeding up slowing down maintaining speed
Was the other vehicle? speeding up slowing down maintaining speed

Did the impact cause your car to? Move forward hitting nothing move forward, hitting car in front move backward roll over
Spin around hitting nothing spin around hitting another car spin around hitting another object

Did you hear or see anything to warn you of the impact? yes no Were you able do to anything to avoid the impact? _____

Was the impact from the? front rear left right other _____

At impact were you? unaware of impact aware of impending impact & relaxed aware & braced for impact
neck and body facing forward neck and or body turned to L R looking in rear view mirror

Were both hands on the steering wheel? yes no If no, then which hand? left right neither

Was your foot on the brake? yes no If yes, which foot? left right both

During the collision did your body move? back and forward forward and back sideways thrown from seat ejected from vehicle

Indicate if your body hit or was hit by any of the following:

Please draw lines and match the left side to the right side.

Head	Headrest
Face	Windshield
Shoulder	Steering wheel
Neck	Side door
Chest	Dashboard
Hip	Car frame
Knee	Another occupant
Foot	Seat
	Seat belt

Check if any of the following vehicle parts broke, bent, or were damaged in your car

Windshield	Seat frame	Knee bolster
Steering wheel	Side/rear window	Other: _____
Dash	Mirror	Other: _____

Did anything strike you in the car? yes no
If yes, what ? _____

AFTER THE COLLISION

After the collision were you? conscious dazed unconscious able to walk out of car unable to get out of car

Did you have any? cuts or lacerations stitches bumps or bruises If yes, have you taken pictures of them? yes no

Did you go to the hospital? yes no If yes, did you go immediately next day other: _____

What hospital? _____ Did you get there by? ambulance your vehicle other vehicle

Were X-rays or MRI taken? yes no Were you treated at the hospital? yes no Were you given medications? yes no
Did you take them? yes no

Have you received any other treatment for this injury? yes no If yes, by whom? _____ Address:_____
_____

Have you tried any of the following self treatment since the injury ?
I self-treated with over-the-counter drugs I took hot showers I used hot packs
I used ice I did stretches/exercises at home Other _____

Doctor Notes:

_____

_____

_____

_____

MEDICAL LEGAL

Were the police notified ? yes no If yes, was there a police report? yes no

Were there any witnesses? yes no If yes, did you get their contact info? _____

Were any citations issued? yes no If yes, to whom ?_____

PAST HISTORY

Have you had any previous auto accidents, work, sport or other significant injuries? yes no If yes, describe including date(s) and any area injured.

_____

Did you receive treatment? _____

_____

Did you have any physical complaints before the accident? yes no If yes, please describe

_____

Have you had any surgeries? yes no If yes, describe._____

Have you ever consulted a chiropractor? yes no If yes, who? _____

Are you pregnant? yes no If yes, what is your due date ? _____

Do use tobacco? yes no if yes smoke ___pks per day __ chew/dip __ vape If you quit tobacco, when?_____

Are you taking any medications? Yes no What kind ? _____

Do you take vitamins or supplements? yes no What kind ? _____

Do you follow a particular nutritional or dietary program? Yes no If yes, describe _____

Do you have any allergies to food, medication, anything else? _____

Do you exercise regularly? yes no If yes what type and how often ? _____

_____

Fees are payable at the time x-rays, examinations, and treatments are rendered unless other arrangements are made in advance.

_____ _____

Patient's Signature **Date**

Doctor Notes:

_____

_____

_____

_____

_____

WELCOME TO OUR OFFICE

Full Name _____ Nickname _____ Date _____
Address _____ Apt. # _____ Age____ Date of Birth ___/___/____
City, State _____ Zip_____ Mobile/Cell Ph# _____
Work Ph# _____ Home Ph#_____

As part of your care in our practice may we add you to a subscriber to our website? We may send a welcome to our practice message & 1-2 monthly emails to help you get well and stay well. Unsubscribe at any time, your address will not be shared.

Email address _____@_____

Please choose appointment reminder preference, (you many check more than one) [ ] Text [ ] Voice message [ ] email

Gender: [ ] Female [ ] Male [ ] Transgender [ ] Other _____

Relationship Status: [ ] Married [ ] Partnered [ ] Single [ ] Widowed [ ] Divorced [ ] Separated #of Children _____

Health has become global, as part of your Health History it is helpful to know

Where you were born? _____ Your Ethnic origin?_____
Where have you traveled ? _____
Employer _____ Employers Address _____
Years Employed ____ Job Title _____ Type of Work _____
Partner/Spouse's Name _____ Partner/Spouse's Employer_____
Name of Insurance Company _____ Phone# _____
Are you insured through spouse, partner or parent? Yes No If so, who ? _____
Their Date of Birth ___/___/___ Employer _____

Payment will be [ ] Cash [ ] Check [ ] Credit Card [ ] Workers' Comp [ ] Health Ins. [ ] Medicare [ ] Auto Ins. [ ] Lien

Who is your Primary Care Physician? _____Phone: _____
Address _____Fax: _____

To help your first visit go smoothly here is what you can expect during approximately the next 45-75 minutes:

1. Paperwork Give your forms to the receptionist when you have completed them. The doctor will use this information to learn about your present health status. **If this visit is regarding an auto accident, a work injury or managed care please let us know, additional forms may be required.** Also take a moment to review and sign our financial policy.

2. Consultation You will meet the doctor, who will review your paperwork and discuss your health history and your present complaint. You will be advised of the cost of any office procedure.

3. Examination A complete examination will be performed. Afterwards the doctor will review the results and determine if Chiropractic can help you. When appropriate, you will be referred to other health care professionals or if X-rays are needed.

4. Initial Treatment If you are currently in pain, initial pain relief treatment will begin on your first visit. This may consist of any of the following:

Chiropractic Adjustment - The doctor will use a carefully directed and controlled pressure to begin restoring normal motion and position to the movable bones of your spine. You may feel or hear a slight pop or snap, which is due to joint movement.

Additional Therapy Procedures such as heat, ice, traction, electrical therapy, ultrasound, and diathermy. These procedures are helpful to reduce the pain, spasm, inflammation, or stiffness you may have.

5. Home Therapy The doctor may suggest home use of ice, heat, or stretching exercises, nutritional supplements, and orthopedic supports to reduce your discomfort.

6. Future Visits On your next visit plan to spend 30 - 45 minutes to receive the doctor's report of findings and additional treatment. You are always welcome to bring any family members or friends along so they can learn about your condition.

We hope this information will help to make your first visit more pleasant. If you have any questions don't hesitate to ask. If you were referred by one of our patients let them know we appreciate it.
After you have read this form please initial here. _____

JOHNSON CHIROPRACTIC OFFICE POLICY

We ask your cooperation in reading and signing this agreement, please initial that which applies:

_____ **I have insurance coverage *that covers* chiropractic** and understand that the insurance company does not always pay in full. I agree to pay the estimated portion at the end of each week or visit, depending on the frequency of my visits. Insurance billing is done as a courtesy to patients and I am ultimately responsible if the insurance company does not pay in full.

_____ **I have insurance coverage that *does not* cover chiropractic or has a high deductible.** Insurance billing is done as a courtesy to patients and I am ultimately responsible if the insurance company does not pay in full.

_____ **I do not have insurance coverage** and understand that payment in full will be required at the time of the visit or at the end of the week, depending on the frequency of my visits. Payment plans are also available.

_____ **I have Medicare.** I understand that Medicare requires an annual deductible, and a 20% co-pay. I understand that Medicare does not cover x-rays, which may be necessary.

_____ **I was injured in a motor vehicle collision or a slip and fall.** I have: (circle what applies)
Auto Medical Pay Coverage / An Attorney / Private Insurance / None of the above
Regardless of the coverage I understand that I am ultimately responsible for the bill.

_____ **I was injured on the job** and covered by worker's compensation. I am aware that if, for some reason, worker's compensation Insurance does not pay for my care, that I am ultimately responsible for my bill.

AS A CONDITION TO THE DOCTOR PROVIDING SERVICE TO ME, I AGREE TO THE FOLLOWING:

1. Returned checks are subject to a charge of $10.00
2. Balances past 30 days may be subject to an interest charge of 1.5% per month unless prior arrangements are made.
3. Payments are due 10 working days after the postmark of statements. Rebilling may be subject to a charge of $5.00.
4. Patients are responsible for any charges of collection, including but not limited to Attorney fees in the event of a delinquent account.

SCHEDULING:

Maintaining your appointment schedule is important. If you miss scheduled appointments, your care may be dismissed.
A $25.00 fee may apply unless a minimum of 24 hours is given. Emergencies are taken into consideration.

I have read this agreement and agree to its terms, I understand that I may request a copy if I desire.

_____ _____
DATE PRINT PATIENT NAME

_____
SIGNATURE OF PATIENT

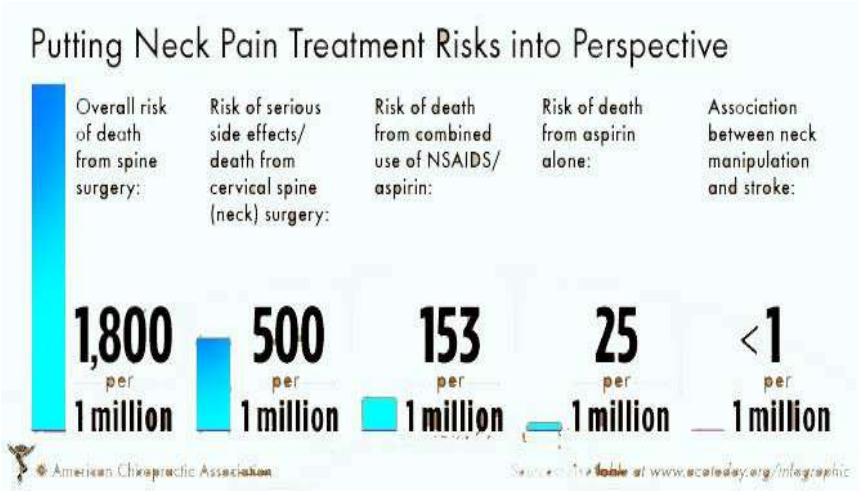
INFORMED CONSENT TO CHIROPRACTIC EVALUATION AND TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on myself (or the patient named below, for whom I am legally responsible) by Dr. Bob J. Johnson and or other licensed doctors of chiropractic who now or in the future treat me while employed by, working with or associated with or serving as back-up for Dr. Bob J. Johnson including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Bob J. Johnson and /or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based on the facts then known, is in my best interests.

I have, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.



To be completed by patient:

_____
Patient Name

_____
Signature of Patient

_____
Date Signed

_____
Witness to Patient's Signature

To be completed by patient's representative, if necessary, if patient is a minor on physically or legally incapacitated:

_____
Patient Name

_____
Name of Patient's Representative

_____
Signature of Patient's Representative

As:_____
Relationship or authority of Patient's Representative

_____
Date Signed

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Your Doctor of Chiropractic is required by law to protect your health information for privacy and confidentiality. Please read it carefully.

We May disclose your health information regarding:

Treatment- to other healthcare professionals within our practice, substitute healthcare provider and or your primary care physician.
Payment- to insurance companies regarding payment or health care operations.
Workers Compensation- to comply with State Workers' Compensation Laws
Emergencies- to notify or assist your family/responsible person in case of injury or death.
Public Health- to public authorities for purposes of preventing/controlling disease, child abuse, reactions to medicines, and reporting disease or infection, for example.
Judicial and Administration Proceedings
Law Enforcement- to identify/locate a fugitive, material witness or missing person, subpoena compliance, etc.
Deceased Persons- to coroners or medical examiners.
Organ Donation- to organizations that procure, bank, or transplant organs and tissues.
Research- to researchers for research approved by an Institutional Review Board.
Public Safety- to prevent/lessen imminent threat to the public's health or safety.
Specialized Government Agencies- to military, national security, prisoner and Gov. benefits purposes.
Change of Ownership of this practice- to mergers or new owners
Referral Board- posting name on our referral board.
Your Health Information Rights- you may inspect and copy your health info, request restrictions on certain uses and disclosures, have your information received or communication through alternative methods, sent to alternative locations, amend your health information, receive full accounting of health info, and have a paper copy of this document after signature. Your Doctor of Chiropractic is not required to agree to restrictions, to amend your info, can deny or not amend upon your request, and will provide a formal explanation of reasons for denial, and information about how to disagree with the denial.
Changes to this Notice of Privacy Practices- Your Doctor of Chiropractic can amend this document. If you have questions regarding anything in this document you can contact this office at 858-578-5776 or make a personal appointment within 2 working days.
Complaints- Contact Office Manager at 858-578-5775 or make a personal appointment within 2 days. Further complaints can be directed to DHHS, Office of Civil Rights, 200 Independence Ave, S.W., Room 509F HHH Bldg, Washington, DC 20201

I have read the Privacy Notice and understand my rights and authorize Doctor Johnson, to use and disclose my protected health care information for treatment, payment, and healthcare operations as described above.

_____ _____ _____
Date Patient's Name (print) Patient's Signature

_____
Your Doctor of Chiropractic Officer Signature