Johnson Chiropractic, P.C. 4600 Kietzke Ln #N258 Reno, NV 89502

PATIENT INFORMATION

Patient Name: _____ Today's Date: ___/___/___

Social Security Number _____ Birth Date: ___/___/___ Age: ____ Gender: F M

Driver's License number: _____ State: _____

Patient's E-mail address: _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Mother: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Guardian: _____ Date of Birth: ___/___/___ Phone: (_____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (_____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____ Relationship of emergency contact to patient: _____ Phone (_____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to a work related accident or injuiry? ☐ YES ☐ NO

Did the condition or injury result from *automobile* accident? ☐ YES ☐ Date of accident: ____/____/____

Continued on next page……

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PATIENT INFORMATION, Continued

Patient Name: _____ Today's Date: ___/___/___

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____

Health insurance Id: _____ Group number: _____ Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO If yes, who is the employer? _____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____

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Please answer the questions that follow. An understanding of your past and current health status will help me determine the most appropriate care for you.

Name (print) _____Birth Date: _____ Today's Date: _____

How old are you? _____How tall? _____ How much do you weigh? _____

Are you [ ] right or [ ] left handed?

Review of Systems (use the space after each question to give additional information about that problem; use the back of this sheet if you need more space to give details about any condition):

Do you have skin, hair or nail problems: [ ] Yes [ ] No _____

Do you have mouth and/or throat problems? [ ]Yes [ ] No _____

Do you have nose and/or sinus problems: [ ] Yes [ ] No_____

Do you have ear problems? [ ] Yes [ ] No _____

Do you have eye problems? [ ] Yes [ ] No _____

Do you have chest or breathing problems? [ ]Yes [ ] No _____

Do you smoke? [ ] Yes [ ] No. If "Yes," for how long have you smoked? _____Amount per day? _____

Do you have heart or blood vessel problems? [ ] Yes [ ] No _____

Do you have blood or lymph note problems? [ ] Yes [ ] No _____

Do you have digestive problems? [ ] Yes [ ] No _____

Do you have genital problems? (e.g. prostate, testicular, vaginal) [ ] Yes [ ] No _____

Do you have urinary (including bladder and kidney) problems? [ ] Yes [ ] No _____

Females: Have you had menstrual problems? [ ] Yes [ ] No _____

Have you ever taken birth control pills? [ ] Yes [ ] No If "Yes," for how long? _____

Is there any chance that you are currently pregnant? [ ] Yes [ ] No

Do you have breast problems? [ ] Yes [ ] No _____

Do you have nervous system diseases and/or mental health problems? [ ] Yes [ ] No _____

Do you have gland or hormone problems? [ ] Yes [ ] No _____

Do you have allergy or immunity problems? [ ] Yes [ ] No _____

o you have muscle, tendon or ligament problems? [ ]Yes [ ]No _____

Do you have any bone (e.g. osteoporosis) or joint (e.g. arthritis) problems? [ ] Yes [ ] No _____

Signature: _____ Today's Date: _____

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Name (print) _____Birth Date: _____ Today's Date: _____

Past and Current Information:

Have you ever (at any time) experienced any of the following:

Difficulty urinating	Y N	Claustrophobia (fear of small spaces)	Y N
Loss of bladder control	Y N	Spinal surgery	Y N
Loss of bowel control	Y N	Common Cold/Flu	Y N
Temporary loss of vision in one eye	Y N	Carotid Artery surgery	Y N
Blood in urine	Y N	Breast Removal	Y N
Difficulty speaking clearly	Y N		

Have you ever been diagnosed with or told you have any of the following?

Detached retina	Y N	Rheumatoid Arthritis	Y N
Stroke	Y N	Fractured bone or broken vertebra	Y N
Slipped Disc	Y N	Bleeding disorder	Y N
Osteoporosis	Y N	High Blood Pressure	Y N
Herniated Disc	Y N	Blood in your stool	Y N
TIAs (mini strokes)	Y N	Cancer	Y N
Drop Attacks (collapsing but not fainting)	Y N	AIDS	Y N
Hardening of the arteries	Y N	Kidney disease	Y N
Partial or complete paralysis	Y N	Prostate disease	Y N

Are you currently or within the last year: Received chemotherapy? Y N Radiation therapy? Y N

Taken blood thinners: Y N

Do you have any surgical/medical implanted devices such as:

Rods, pins or screws? Y N	Artificial joints? Y N	Pacemaker? Y N
Artificial heart valve? Y N	Surgical wires/clips? Y N	Hearing aid? Y N

Signature: _____ Today's Date: _____

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Name (print) _____Birth Date: _____ Today's Date: _____

Past and Current Information Continued:

In the past 14 days (two weeks) have you experienced any of the following? If so, please circle which ones: If you have not experienced any of the following, please initial here: _____

Nausea	Vomiting	Vertigo (Spinning)	Incoordination
Difficulty Walking	Numbness or other sensory complaints		Loss of consciousness
Double Vision	Blurred Vision	Tinnitus (ringing in ears)	Speech Problems
Clumsiness	Memory Loss	Travel by Car or Truck	Personality Changes
Fever	Recurrent Headaches	Diarrhea	Skin Rash/Infection
A major Fall	A minor Fall	An auto accident	A work injury
Loss of Strength	Painful bowel movements	Head trauma	

Have you been to a Chiropractor before? [ ] Yes [ ] No
If "yes," when was your most recent visit? _____
For what problem(s)? __Same as current __Other: _____
Previous Chiropractor's name: _____
Location: _____
Do you have a family physician? [ ] Yes [ ] No
If "yes," their name: _____
Address: _____
Most recent visit: _____ Reason for that visit:

Have you been under the care of a medical specialist or other health care provider within the past year? [ ] Yes [ ] No If "yes," what specialty and when:

If you are working: Describe your work activities:

How many hours per day? _____ Days per week? _____
Do your current complaints limit your ability to do your normal work? [ ] yes [ ] no If "yes," in what way?

Does your work make your current problems worse? [ ] yes [ ] no If "yes," how?

If you are retired: When did you retire? _____

What type of work did you do before you retired? _____

Do you currently work or do volunteer activities? _____

Signature: _____Date_____

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Name: _____ Date: _____

And finally…. What is the ***primary or main problem*** for which you are seeing Dr. Johnson? _____

_____

This problem started on (day/date)_____
What happened? _____

I don't have a specific date when this started, but it has been bothering me for about _____ ( ) Days

( ) Weeks ( ) Months ( ) Years

Since it began, my discomfort has: ( ) stayed the same ( ) gotten worse ( ) improved.

It is: ( ) constant ( ) frequent, about _____ times a day or ( ) occasional, ___times a week.

It ( ) does or ( ) does not awaken me at night.

I feel: [check all that apply]:

( ) pain	( ) numbness	( ) tingling	( ) weakness
( ) stiffness	( ) soreness	( ) swelling	

My symptoms are usually ( ) mild or ( ) moderate or ( ) severe

When I have pain, it is [check all that apply]:

( ) dull	( ) aching	( ) burning	
	( ) sharp	( ) shooting	( ) throbbing

Circle the number that best indicates your usual level of discomfort or pain:

None at all (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Worst pain ever

Any other information regarding this problem?

If there are other problems or health concerns you wish to discuss with Dr. Johnson, use the space below to list those (use back of this page if you need more space). If there are no other concerns, initial here:_____

Signature_____ Date: _____

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Name: _____ Date: _____

Prescription Medications you are currently taking:

Name of Medication	Prescribed by:	Reason for taking:

Continue on back of page if you need more space…….

What over-the-counter (non-prescription) medicines are you using?

Name	Reason for taking:

Continue on back of page if necessary……

List any vitamin/mineral/herbal supplements you are using:

Name	Reason for taking:

Use back of page if you need more space……

Signature_____Date_____

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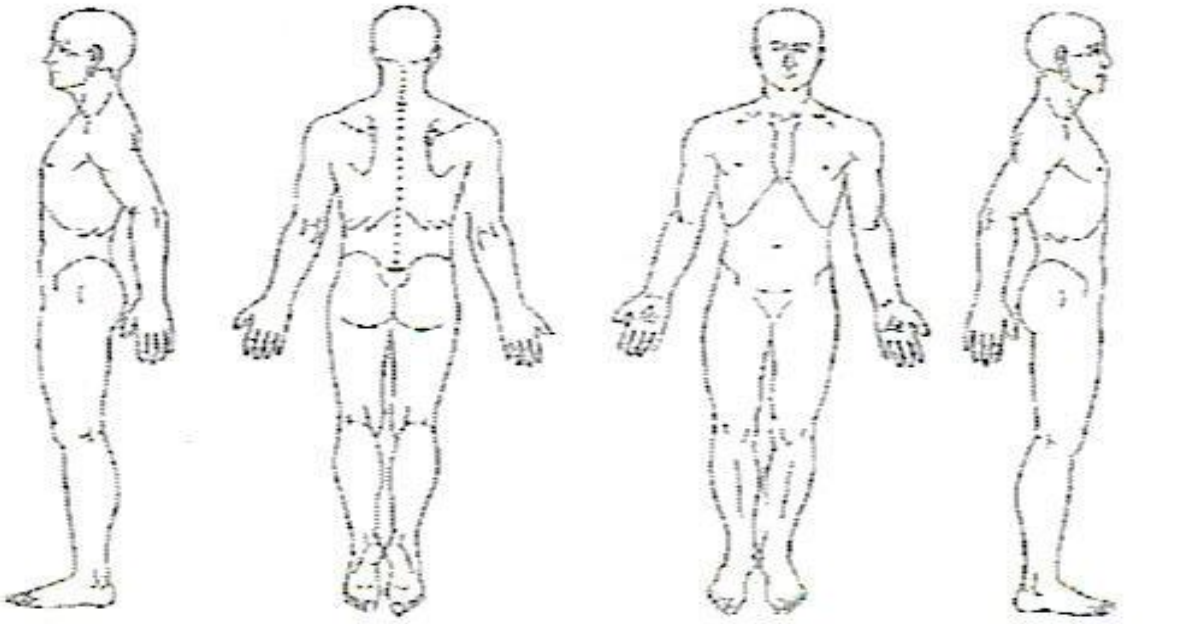
PATIENT INFORMATION

Name (print) _____Birth Date: _____ Today's Date: _____

Description of Condition

Add the following letters to the body diagrams to help me better understand your condition:

A =Ache N =Numbness B = Burning T = Tingling S = Stiffness O = Other



Use this space to give me any other details not already given about your symptoms:

Signature: _____ Today's Date: _____