Patient History & Examination

Name_____ Email Address_____

Home Phone ( ) _____ Cell Phone ( ) _____

Address_____ City_____ State_____ Zip_____

HT._____ WT._____ Age_____ Birthdate_____ Sex M F Marital Status M S W D P No. Children_____

Occupation_____ Employed By_____ Phone ( ) _____

Address_____ City_____ State_____ Zip_____

Social Security No._____ Driver's License No._____

Spouse's Name_____ Employed By_____ Phone ( ) _____

Referred By_____

Accident – Injury Information

Date of Accident_____ Time_____ AM/PM Was Employer Notified? _____

Last Day Worked? _____ Accident Location & Description_____

_____

Previous Treatment For This Condition

_____DC _____MD Other_____ Name_____

Results_____

Have You Been Placed On Disability? _____ By Whom?_____

From_____ To_____

Health History – List Drugs You Are Now Taking

_____

Do You Have? TB_____ VD_____ In The Past_____ Cancer_____ Diabetes_____

Surgery History

☐ Appendix ☐ Tonsils ☐ Hernia ☐ Hemorrhoid ☐ Spinal ☐ Hysterectomy ☐ Prostate ☐ Cyst ☐ Cancer

List Others_____

List Fractures/Dislocations/Concussions Present & Past _____

_____

List Previous Accidents/Injuries/Major Illnesses_____

_____

_____

Family Physician_____ Phone ( ) _____

Address_____ City_____ State_____ Zip_____

Nearest Relative (Not living with you) _____

Address_____ City_____ State_____ Zip_____

Phone ( ) _____ Relationship_____

Payment Arrangements Are Expected When Services Are Rendered

I understand and agree that health and accident Insurance policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that the Chiropractic Office will prepare a super bill that I can submit to my health insurance. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time the services are provided. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature_____ Date_____

PATIENT SYMPTOMS COMPLAINTS

FOR _____ DATE _____

IMPORTANT: Circle all present symptoms. Underline recent past symptoms. Sign below. Be Complete.

MUSCLE, LIGAMENT & JOINT

NECK: Weakness - Pain - Stiffness - Swelling - Spasms - Disc - Limited Movement - Pain on Motion - Surgery - Throat Muscles Swollen or Sore. Worse: After Sleeping - During Day - End of Day.

MID BACK: Weakness - Pain - Spasms - Soreness Worse: After Sleeping - During Day - End of Day.

LOW-BACK: Weakness - Pain - Stiffness - Swelling - Limited Movement - Pain on Motion - Surgery. Pain When: Sitting - Walking - Standing - Sleeping. Worse: After Sleeping - During Day - End of Day. Sacroiliac - Tailbone - Sex Impotency - Pain in Groin
Worse: After Sleeping - During Day -End of Day.

EXTREMITIES & RADIATING PAIN

HEAD & HEADACHE: Side - Front - Top - Heavy Head - Affects Vision - Produces Nausea - Throbbing - Incapacitating - Handicaps Normal Function - Migraine.
Worse: After Sleeping - During Day - End of Day.

SHOULDER: Local Pain - Radiates Down Arm - Pain on Movement - Limited Movement - Pain from Neck.
Worse: After Sleeping - During Day - End of Day.

ARM: Local Pain - Radiating Pain - From Neck - On Movement - Down Arm - Numbness - Tingling - Elbow - Wrist - Fingers - Swelling - Heaviness - Cold Hands - Grip Strength Loss - Can't Raise - Drops Things.

HIP, KNEES, LEGS: Local Pain - Radiating Pain - From Back - On Movement - Down Leg - Knee (Front - Back) Numbness - Tingling - Knee Swelling - Ankle Swelling - Charlie Horses - Cramps - Spasms - Varicose Veins - Heaviness - Pain on Walking - Sitting - Prolonged Standing.

FEET: Swelling - Discomfort - Pain - Pain on Walking - Pain with Back Problem - Corns - Callouses - Bunions - Fallen Arch - High Arch - Toe-in - Toe-out - Cold - Burn.

MUSCLE & LIGAMENTS

Sprain - Pulled - Torn - Atrophy

SPINE & DISC

SPINE: Surgery - Arthritis - Curvature - Whiplash.

DISC: Surgery - Protrusion - Compressed - Degenerating - Deteriorating - Herniated - Ruptured.

NERVES

Burning - Numbness - Tingling - Pins and Needles - Tremor - Nervousness - Nervous Tension - Nervous Fatigue - Dizziness - Poor Equilibrium - Loss of Balance.

ENERGY AND FATIGUE

Intermittent - Constant - Occasional.
Exhaustion Build-up - Tired Upon Awakening - Exhaustion After Work - Must Rest During Day

WALKING CAUSES: Tiredness - Fatigue - Exhaustion.

SLEEPING: Good - Fair - Poor - Poor Due to Pain - Insomnia - Falls to Sleep - Emotional Fatigue - Excessive Sleep.

EYE, EAR, NOSE THROAT & MOUTH

EYE: Pain - Strain - Red - Blurring - Light Hurts - Double Vision - Spots - Injury - Pressure - Glasses.

SIGHT: Far - Near - Failing - Glasses.

EAR: Ache - Infection - Noises - Ring - Buzzing.

HEARING: Good - Poor - Aid - Failing.

NOSE: Post-nasal Drip - Bleeding - Obstruction - Sneezing - No Smell.

THROAT: Sore - Dry - Hoarse - Phlegm - Enlarged Glands - Swallow.

MOUTH: Bad Taste - Teeth - Breath - Gums - Sores - Eruptions - No Taste.

TEETH: Good - Bad - Abscess - Grinding - Dentures: Fit Well - Poor.

HEART AND CIRCULATION

HEART: Slow - Rapid - Pain - Palpitation - Past Attack - Coronary - Chest Pain - Pain Down Arm - Difficult Breathing.

BLOOD PRESSURE: High - Low Irregular - Past Stroke - Paralysis: L - R.

CIRCULATION: Good - Poor - Swelling.

COLD: Hands - Feet - Body - Varicose Veins - Hardening Arteries.

SWEATS: Excess - None Hot - Cold - Night.

BLOOD: Problems - Disease - Anemia.

LUNGS AND BREATHING

LUNGS: Difficult Breathing - Congestion - Asthma - Emphysema - Wheezing - Bronchitis - Infection.

COUGH: Blood - Phlegm - Dry - Sneezing.

STOMACH, LIVER, GALL BLADDER AND INTESTINAL

STOMACH: Nausea - Pain - Ulcer - Vomiting Blood - Bile - Indigestion - Heatburn - Gas.

APPETITE: Good - Poor - Excess.

LIVER: Upset - Jaundice - Hepatitis.

GALL BLADDER: Attack - Infection - Stones.

INTESTINES: Bloat - Mucous - Constipated - Diarrhea - Hemorrhoids - Fissures - Colitis.

KIDNEY, BLADDER & URINATION

URINE: Frequent - Difficult - Burns - Blood - Pus - Irritates - No Control - Infection - Kidney Stones - Prostate - Ovaries - Bedwetting.

SKIN

Sensitive - Bruises - Dry - Itching - Rash - Hives - Shingles - Boils - Acne - Eruptions - Slow Healing.

GENERAL

SWOLLEN LYMPH NODES: Neck - Underarm - Groin - Face - Pallor - Chills - Fever - Flu - Virus - Chronic Cold - Cough.

SINUS: Congestion - Headache - Sneeze.

WEIGHT: Over - Under - Loss - Gain.

REACTION TO DRUGS: Mild - Severe - Occas.

PERSONAL HABITS

Hrs. Regular Sleep/night _____

Amount of Smoking _____ Pkg/day

_____ Cups /day

_____ Week

_____ Week

PERSONAL INJURIES & ACCIDENTS (dates)

AUTO ACCIDENTS: Recent - Past _____

WORK INJURIES: Recent - Past _____

FALLS & OTHERS: Recent - Past _____

GIVE DOCTOR FULL DETAILS

FOR WOMEN ONLY

MENSTRAL: Cramps - Backache - Excess Flow - Difficult - Irregular - Tension.

MENOPAUSE: Symptoms - Hot Flashes - Extrogen.

VAGINAL: Discharge - Irritation - Odor

MISCARRIAGES _____ PREGNANCIES _____

Unable to Become Pregnant. Self - Husband.
Currently pregnant

Absolutely no patients accepted for diagnosis or treatment of Cancer. Suspected cases of Cancer are immediately referred.

DATE _____ PATIENT SIGNATURE _____

GUARDIAN SIGNATURE _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including diagnostic x-rays or MRI, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, disc irritations, strokes, dislocations and strains.

I am also informed that in the history of Directional Non-Force Technique® chiropractic, to the extent known by the below doctor, there have been no strain, sprain, dislocation, fracture, or stroke injuries reported since its earliest date of application in 1945. Although under certain rare circumstances such injuries could be theoretically possible, they carry a remote probability when based upon patient history of the technique protocol.

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 procedure which the doctor feels at the time, based upon the facts then known, in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____

Doctor of Chiropractic Name: Christopher John, DC

Signature of Doctor of Chiropractic: _____

Date:_____

Missed and Cancelled Appointment Policy – 2022 Update

Dr. John's chiropractic practice can best be described as **high quality / low volume**. Our current Covid-19 protocols and practice schedule require that a person arrive on time to maintain our standards and assure full treatment time allotted.

We value every patient's appointment as special, and we do not over-book or cluster-book to compensate for those who might forget or not show. Our policies, therefore, are:

A **new patient appointment** that is cancelled or re-scheduled more than one week in advance of the appointment.	**No charge**
A **new patient appointment that is cancelled with <u>less than one week</u>** in advance of the appointment. No charge if it appt can be re-scheduled to earlier date.	**Forfeit $100 deposit**
An **established patient appointment** rescheduled or canceled with **more than 72 hours notification** in advance of the appt, ***except for Monday appointments (if they return to the schedule)*** *- see below.* *****	**No charge**
An established patient appointment that is **missed** (no communication prior to the missed appointment).	**Double $120** **Single $60**
An established patient appointment that is **cancelled with less than 72 hours notification**. If rescheduled to a later or earlier slot *on same day, if possible*, see the policy on bottom row. ******	**Double $100** **Single $50**
* **A Monday established appointment (if/when a Monday schedule is available)** that is cancelled ***after business hours on the Friday*** before (ie between Friday afternoon and Monday morning). If Monday is a holiday, then this would apply to Tuesday, the next day of business. This means a $100 fee would apply, even though a message may have been left more than 72 hours of the actual Monday appointment.	**Double $100** **Single $50**

_____
initial

- We now have an online scheduling system that patients can utilize to create appointments for themselves, as well as our office making them. This online system sends an automated confirmation at the time of the appointment creation.
    - In addition, there is an automated app reminder by Email and text **24 hours prior to the appointment time**.
    - We therefore do not make reminder phone calls from our office and **patients are responsible for their own appointments with or without any reminder**.

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initial

To be consistent, we **cannot judge or grant exceptions**, even though there may sometimes be circumstances out of one's control. Policies and fees are subject to change without notice.

Thank you for your understanding and respect.

I have read and agree to the above office policies:

_____

(Signature)