WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

PATIENT CONDITION

Reason for Visit _____

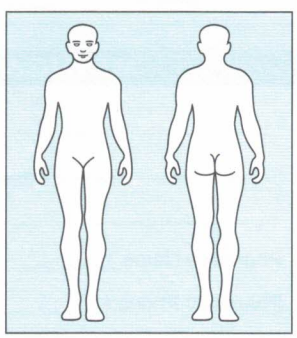
When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name_____

Pharmacy Phone (_____)_____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Name _____ Date:_____ Age: _____

L or R handed? Left Right

Height: _____

Weight: _____

Any unexplained weight loss? Yes No

Has pain been greater the last 4 weeks? Yes No

Does pain improve with rest? Yes No

Have you had failure to respond to conservative care in the past? Yes No

Any prolonged use of corticosteroids? Yes No

If yes, which type? _____

Any intravenous drug use? Yes No

Any recent / current infection? Yes No

If yes, what type: URI, UTI, Sinus, Ear, Other: _____

Immunosuppression condition / medication? Yes No

If yes, what type? _____

Any sunburns or open wounds? Yes No

If yes, please specify where: _____

Any muscle weakness? Yes No

Any bowel problems? Yes No

Any urinary problems? Yes No

Any history of cardiac problems? Yes No

Any history of seizures? Yes No

For women, any chance you're pregnant? Yes No

Is this your first Chiropractic visit? Yes No

If no, when / where was last visit? _____

Integrated Chiropractic

2206 Jo-An Drive STE 1
Sarasota, FL 34231
(941) 487-0266

Dr. Ryan Johnson, D.C.

Informed Consent to Chiropractic 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 me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed above or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic 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 the practice of chiropractic care, 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 the risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that there are other medical treatments and options available to me at this time including but not limited to medications, injections, or surgeries. I am choosing to receive chiropractic care and acknowledge that I am of sound mind at the time of signing this document.

I have read, or have had read to me, the above consent, 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.

Print Patient's Name _____

Patient (Legal Guardian) Signature _____

Date _____

Office Signature _____ Date _____

integrated CHIROPRACTIC

BRAIN. BODY. BALANCE.

2206 Jo-An Drive, STE 1

Sarasota, FL. 34231

941-487-0266

Dear Patient:

Please read, initial, and sign:

We **do not accept** 3rd party health insurances such as Blue Cross, Cigna, or Aetna.

Insurances we accept are Medicare Part B, PIP (Auto), VA (Veterans) and Meritain (Sarasota Memorial.)

New patient Consultation, Review of History, Examination, and a Report of Findings (with a detailed treatment plan) is $140.

Returning patients are considered a new patient after 3 years of no appointments. After a year of no appointments, or with a new issue, a re-examination is required.

A routine office visit can vary from $32 - $100 (estimated) depending on what services (and/or products) are rendered, as required by your treatment plan.

Our office policy regarding cancellations and rescheduled appointments is as follows:

1. For cancelled appointments, without a prior 24-hour notice, there will be a $60.00 charge to the patient's personal account for chiropractic services, and or nutritional appointments. We understand emergencies can occur and will address those on an as needed basis.
   Initial _____

2. As per OSHA regulations, as well as for the safety of our patients, no returns are allowed on any nutritional supplements purchased from this office.
   Initial _____

Notice

I understand that I am responsible for payment of my account at the time services are rendered, and that I am financially responsible for all charges whether or not paid by insurance. If Integrated Chiropractic INC. is forced to take any action for collection of a balance owed, either by lawsuit or by other means, I agree to pay all collection costs, including attorney's fee(s) and an interest charge of 1.5 % per month (18% annually) on the amount owed until paid.

Print Name: _____

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or decline the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below I authorize being contacted for practice reminders by:

Email: _____@_____.com
Phone Calls (_____) _____-_____
Text message (_____) _____-_____ same
Cell Phone Carrier: sends text reminder day before your scheduled appointment

Please circle: AT&T Boost Mobil Cricket Metro PCS Nextel Sprint
T-Mobil US Cellular Verizon Virgin Mobile Other:_____

_____ By initialing, I authorize being contacted for birthday greetings, or promotions by Integrated Chiropractic.

_____ By initialing, I authorize Dr. Johnson to personally discuss with me products that may benefit my health or condition

_____ _____
Patient Name (Print Please) Name of Parent, Guardian or Legal representative

_____ _____
Signature of Patient/Parent/Guardian/representative Date

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS

List below the names and relationship of people to whom you authorize the Practice to release PHI

_____ _____

_____ _____

_____ _____

_____ _____

Health and Wellness Analysis

Do you any have children? ❑Yes ❑No If yes, please list ages _____

Please list all food cravings: _____

_____

Do you eat organic foods: ❑Yes ❑No

- If yes, what percent of total food intake is organic? _____

Do you avoid certain foods? ❑Yes ❑No

- If so, please list which: _____

Do you eat the recommended 7-13 servings of fruits/vegetables daily? ❑Yes ❑No

Do you have any food allergies? ❑Yes ❑No

- If yes, please list with severity (Scale 1-10) _____

_____

How many bowel movements do you have per day? _____

- If not daily, how many per week? _____

Please circle/list any other digestive issues you frequently experience:

Gas Bloating Belching Acid reflux _____

On Average:

- What time do you go to bed? _____
- How many hours of sleep do you get per night? _____

Do you sleep through the night? ❑Yes ❑No

- If awakened, what is the time/reason? _____

Rate your energy level: (1=low, 10=high)

1 2 3 4 5 6 7 8 9 10

Would you like to experience weight gain or weight loss? ❑Yes ❑No

- If yes, how many pounds? _____

On average, how often do you exercise? _____

On a scale from 1-10 (1=low, 10=high), how would you rate your willingness to be coached and make changes to your currently lifestyle to address your health challenges?

1 2 3 4 5 6 7 8 9 10