Johnson Chiropractic Clinic
Dr. Scott Johnson

HUB CITY CHIROPRACTIC
Dr. Casey Voehl

Welcome To Our Office!

Date _____

Name _____ Birthdate _____

Address _____ City, State, Zip _____

Home Phone # _____ Cell Phone # _____ Email _____

Social Security # _____ Sex - M F Height _____ Weight _____

Marital Status - M S D W # of Children ____ Spouse's Name or Parent _____

Your Occupation _____ Employed By _____ Work Phone # _____

Address _____ City, State, Zip _____

Who may we thank for referring you to our office? _____

- – -

Major Medical Insurance Co. _____ Policy Holder _____

Group # _____ I.D. # _____

Any Other Health Insurance Co. _____ Policy Holder _____

Group # _____ I.D. # _____

Medicare _____ Medicare # _____

Is this injury or illness work-related? - Y N Have you reported it to your employer? - Y N

Is this injury or illness related to an automobile accident? - Y N (if yes, name of:)

Your Auto Ins. Co. _____ Policy # _____ Claim # _____

Address _____ Agent's Name _____

- – -

Have you ever had Chiropractic Care before? - Y N If yes, when? _____

List your chief complaints in order of severity:

(1) _____ Start date _____

(2) _____ Start date _____

(3) _____ Start date _____

List other doctors seen for these conditions:

(1) _____ Address _____

(2) _____ Address _____

Are you currently taking any medications? - Y N If yes, please list:

(1) _____ (4) _____

(2) _____ (5) _____

(3) _____ (6) _____

Surgeries (Please include all surgeries)

(1) Type _____ When _____

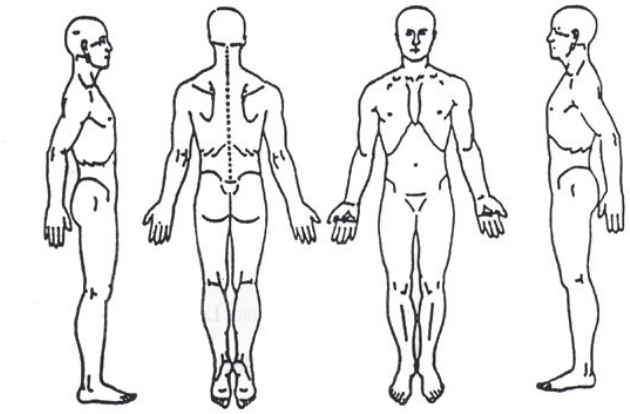
(2) Type _____ When _____

(3) Type _____ When _____

Are you now or have you suffered from any of the following:

- ☐ Stroke
- ☐ Fatigue
- ☐ Migraine
- ☐ Nervousness
- ☐ Arthritis
- ☐ Numbness in arms/legs/hands
- ☐ Pain in arms/legs/hands
- ☐ Pregnant at this time
- ☐ Pain between shoulders
- ☐ Spinal curvature
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Headache
- ☐ Shingles
- ☐ Dizziness
- ☐ Heart attack
- ☐ Cancer
- ☐ Diabetes
- ☐ Sinus pain/congestion
- ☐ Stiff neck
- ☐ Back pain
- ☐ Swollen joints
- ☐ Pinched nerves
- ☐ Thyroid disease

Please mark your areas of pain on the figures below



Describe your symptoms

(1) ☐ Getting worse ☐ Getting better ☐ Staying the same

(2) ☐ Constant ☐ Off and on

(3) ☐ Dull ☐ Achy ☐ Sharp ☐ Stabbing ☐ Burning

☐ Pins and needles ☐ Other _____

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain: 0 Absent to 10 Extreme

CONSENT TO TREAT A MINOR CHILD:

I hereby authorize this office to administer chiropractic care as deemed necessary for my child.

Signature _____(Parent/Legal Guardian) Date_____

FINANCIAL/INSURANCE POLICY:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will process any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. The new patient exam fee of $40.00 is a one time fee due at the time of service. Most insurance will only cover the chiropractic treatment. You are responsible for the new patient exam fee.

MEDICARE: I understand that Medicare only covers one service in a chiropractic office, that is the chiropractic adjustment. I understand that I will be responsible for the payment at time of service of the new patient exam required (by Medicare) at a cost of $40.00. The new patient exam is a one time charge.

Signature _____ Date_____

AUTHORIZATION TO RELEASE INFORMATION

To: Scott A. Johnson, D.C. ; Casey R. Voehl, D.C.

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Signature _____ Date_____

Witness_____