



Johnson Chiropractic Clinic and Integrative Health  
 226 Brandilynn Blvd. Ste. D, Cedar Falls, IA 50613  
 Phone: (319) 266-7788 Fax: (319) 266-8088

**Michael L. Johnson, DC   Michele Green, DC   Valorie Prah, DC, CCN, DACBN**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
 Spouse/Partner's Name \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
 Permanent Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Social Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Email: \_\_\_\_\_

Which is the best to contact you during the day? Home Phone Work Phone Cell Phone Email

Employer: \_\_\_\_\_ Spouse/Partner's Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Spouse/Partner's Occupation: \_\_\_\_\_  
 Describe health of spouse/partner: \_\_\_\_\_ Number of children if any \_\_\_\_\_  
 Name of Child(ren)      Age      Current Health Problems?

**If you're under someone else's insurance policy, please fill in this information:**  
 Name of Insured: \_\_\_\_\_  
 Insured's Phone #: \_\_\_\_\_  
 Insured's Address: \_\_\_\_\_  
 Insured's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you find out about this office?  
Television Google Yahoo Qwest Dex Yellow Book  
Met Dr. \_\_\_\_\_ Saw the Sign Newspaper  
Friend(s)/Family/Coworker(s): \_\_\_\_\_  
My Doctor Referred Me Other: \_\_\_\_\_

What health problems are you struggling with?      How long?  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

Are you in pain? If so how much? (10 is the highest)

10	9	8	7	6	5	4	3	2	1
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What have you tried to make the situation better?      Did it Help?  
 1. \_\_\_\_\_ Yes / No / Somewhat  
 2. \_\_\_\_\_ Yes / No / Somewhat  
 3. \_\_\_\_\_ Yes / No / Somewhat

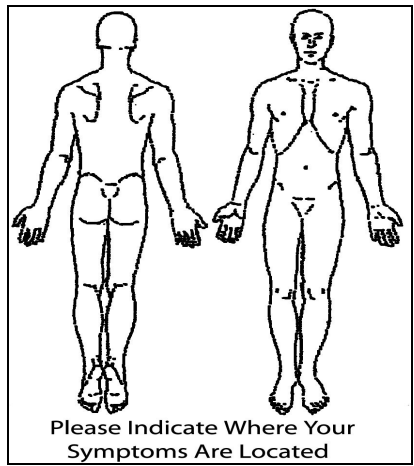
Is it a Work Injury? ( Yes / No ) or Car Accident Injury? ( Yes / No )  
 Please list the name(s) of the doctor(s) or therapist(s) you have seen prior for this:  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been adjusted? Yes / No If yes, when last? \_\_\_\_\_

Do you have a preference on which doctor treats you?  
 I have no preference  Dr. Johnson  Dr. Green  Dr. Prah

What are your goals for treatment?  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

Would you like to integrative other services into your care? What would you be interested in learning more about?  
Chiropractic Acupuncture Inflammation Management Stress Management Training  
Heavy Metal/Chemical Detoxification Nutritional Testing Nutritional Therapy



Please list, by year, any car accidents, work-related, recreational, athletic or other injuries.

Please list, by year, any and all surgeries or hospitalizations you have experienced.

Are you taking any medications or supplements? ( Yes / No ) If yes, please list them and tell what you are taking them for. Attach a sheet if needed.

**Basic Health Review:**

- 1. How much stress do you experience on a scale of 0-10 (10 = highest)? \_\_\_\_ /10
2. Do you feel that you have the skills to cope with stress well? ( Yes / No )
3. Do you take deep breathes when you are stressed, focus on something pleasant? ( Yes / No )
4. Do you drink the equivalent of 8-8oz glasses or 1 liter of water a day? ( Yes / No ) If no, how much? \_\_\_\_\_ oz.
5. How many hours of sleep do you get per night? \_\_\_\_\_ Would you consider it quality sleep? ( Yes / No )
6. How often during the week do you get moderate physical activity? \_\_\_\_ times/week.
7. Do you eat a diet HIGH in vegetables, fruits, whole-grains, low-fat dairy, chicken, fish while LIMITING red meat, sugar, high-fructose corn syrup, trans-fats, and processed food? ( Yes / No )
8. Do you read nutritional labels and understand what they mean? ( Yes / No )
9. Do you supplement with Omega-3's, Vitamin D3, and a Quality Multi-Vitamin (not a "One-a-day")? ( Yes / No )
10. If you have children do you teach them what you know about health and having a healthy lifestyle? ( Yes / No )

**Health Status Review**

Table with 3 columns: C = Current Condition, P = Past Condition, Leaving Blank = No Current or Past History. Rows include various medical conditions like Neck Pain, Ankle/Foot Problems, Crohn's, Colitis, Irritable Bowel, etc.

**Women Only**

- \_\_\_Nursing \_\_\_Irregular Periods \_\_\_Painful Periods \_\_\_Birth Control \_\_\_PMS

For the purposes of possible X-ray, this signature certifies that ( I AM / I AM NOT ) currently pregnant. (Circle one)

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

## Patient Privacy Statement

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Name of Patient

Date