Johnson Chiropractic and Wellness Center

Patient Information

Stephen T. Johnson DC
10700 Old County Road 15 #240
Plymouth, MN 55441
(763)544-2001

Name: ______________________________ M ______ F ______

Address: ______________________________ City ____________ State_____ Zip ________

Date of Birth: ______________ Age _____ Marital Status ______ No. of children ______

Home Phone: ______________________________ Cel Phone: ______________________________

Social Security No: ______________________________ Work Phone: ______________________________

Employer: ______________________________ Occupation: ______________________________

E-Mail Address: ______________________________

I would like to receive Dr Johnson's email newsletter: Yes: _____ No_____

In Case of Emergency contact: Phone:

FINANCIAL POLICY:

CASH ____ AUTO INSURANCE ____ WORK COMP ____ MEDICARE ____

FEES ARE PAYABLE AT THE BEGINNING OF EACH WEEK OR MONTH UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

JOHNSON CHIROPRACITC AND WELLNESS CENTER WILL PROVIDE AN ITEMIZED STATEMENT FOR THE PATIENT TO SUBMIT TO PERSONAL INSURANCE BUT, PAYMENT IS DUE AT THE TIME OF SERVICE.

- I am responsible for bills submitted to me from Johnson Chiropractic and Wellness Center, Dr Stephen Johnson DC.
- **A monthly 1% Finance charge will apply on all unpaid balances that are 60 days past due.**
- Accounts not paid within 90 days will be turned over to accounts not paid within 90 days will be turned over to collections, unless prior arrangements have been made.
- I authorize payment of medical benefits to SDJC Ltd. aka Johnson Chiropractic and Wellness Center, Dr. Stephen Johnson D.C. for chiropractic services rendered on my behalf for which he is a participating provider.
- I authorize the release on any medical information concerning my physical condition to any insurance company, attorney or claim adjuster to process my claim for reimbursement.

RETURNED CHECKS WILL BE CHARGED A $20.00 SERVICE FEE.

PATIENT SIGNATURE (Guardian) ______________________________ Date________________

PATIENT HISTORY

CHIEF COMPLAINT(S): ____

____

QUALITY OF THE PAIN? ___SHARP ___DULL ___ACHING ___ BURNING ___ TINGLING ___NUMB ___ STIFF

SEVERITY OF THE PAIN? ___ MILD ___ MODERATE ___SEVERE **PAIN SCALE** (Low **1-10** High) _____

DOES THE PAIN RADIATE? ___YES ___NO IF YES, TO WHERE?______________________

FREQUENCY OF PAIN? ____ OCCASIONAL ___ INTERMITTENT ___ FREQUENT ___ EPISODIC ___ CONSTANT

HOW DID IT BEGIN? ____

DATE OF INJURY OR ILLNESS: ____

WHAT MAKES IT WORSE? ___ SITTING ___ STANDING ___ LYING DOWN___ MOVEMENT ___ REST

OTHER____

WHAT MAKES IT BETTER? ___ HEAT ___ ICE ___ REST ___ EXERCISE ___ MEDICATION ___USE

OTHER:____

WHEN DOES PAIN OCCUR? ___ MORNING ___ EVENING ___ SLEEPING ___ WITH ACTIVITY

HAS THIS HAPPENED BEFORE? ___YES ___NO IF YES, LAST TIME________HOW MANY TIMES? _____

PREVIOUS ACCIDENTS, FALLS, INJURIES, SURGERIES: ______________________________

____

HAVE YOU SEEN ANY DOCTORS FOR THIS COMPLAINT? ___YES ___NO IF YES, WHAT TYPE?

___FAMILY DOCTOR ___ORTHOPEDIST ___NEUROLOGIST ___CHIROPRACTOR ___ ACCUPUNCTURIST
PHYSICAL THERAPIST ___ MASSAGE THERAPIST ___OTHER______________________

NAME OF DOCTOR(S): ______________________ PHONE NUMBER(S): ______________________

PREVIOUS DIAGNOSTIC TESTS (CIRCLE): MRI CT SCAN X-RAY SPECIAL TESTING (type)____________

RESULTS:____

PAST TREATMENT/SELF CARE:____

OTHER HEALTH CONDITIONS: ____

____

MEDICATIONS/SUPPLEMENTS: ____

______________________________ ______________
Patient (Guardian) Signature Date

Stephen T. Johnson DC- 10700 Old County Road 15, Suite 240, Plymouth, MN 55441
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