Johannes Chiropractic Office
4864 Buffalo Rd.
Erie, PA 16510
899-5400

Dear New Patient:

Welcome to Johannes Chiropractic Office. I realize that entering a new office can be a little scary and a little uncomfortable. I and my staff promise to explain each event as you move through the history taking process, the examination process and the treatment. It is our mission to make your experience at our office as positive as possible.

I want you to feel at ease with asking questions during our time together. I also encourage you to bring a family member or a friend with you to the appointments.

We have been a part of the Harborcreek/Erie communities for the past thirty years. We consider ourselves fortunate to have met and treated thousands of our fellow community members. We take our responsibility seriously and we cherish your confidence in our care.

You are in the right place, at the right time. We are going to help get you well and we are going to do it naturally, with chiropractic care.

Dr. James G. Johannes

Date: _____

Name: _____
Address: _____ City: _____State: _____ Zip: _____
Email address: _____
Home phone: _____Cell phone: _____
Age: _____Date of Birth: _____Race:_____Marital status: M S W D SEP
Occupation: _____
Spouse name: _____
How many children? _____ Ages of children: _____
Emergency Contact: _____Phone: _____
How did you learn about our office? _____
Family Medical Doctor: _____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _Yes _No

History of present illness:
Areas of pain: _Neck _Back _Other: _____
Date symptoms appeared or accident happened: _____
This is directly due to:
Auto (Do you have a claim #? _Yes _No)
Work (Did you file an accident report and have you been authorized to receive care at Johannes Chiropractic Office? _Yes _No)
Other: _____
Have you ever had the same or a similar condition? _Yes _No If yes, when and describe: _____
Days loss from work: _____ Date of last physical: _____
What does this prevent you from doing or enjoying? _____
Has it changed lately? _Yes _No _Same _Better _Gradually worse
How frequent is the condition? _Constant _Daily _Intermittent _Night only
How long does it last? _All day _Few hours _Minutes
Described the pain: _Sharp _Dull _Numb _Tingling _Aching _Burning _Stabbing Other:_____
Is there anything you can do to relieve the symptoms? _Yes _No If yes, describe: _____
What makes the problem worse? _Standing _Sitting _Lying _Bending _Lifting _Twisting _Other: _____
List any major accidents you have had other than those that might be mentioned above: _____
Prior surgeries? List: _____
Women: Are you pregnant or is there any possibility that you may be pregnant? _Yes _No _Uncertain
Do you have a problem with recurring headaches? _Yes _No
Are you losing weight without trying? _Yes _No
Does your pain and wake you up at night? _Yes _No

Have you had a change in bowel or bladder habits? _Yes _No
Have you recently had any unusual bleeding or discharge? _Yes _No
Do you have a thickening/lump in the breast or elsewhere? _Yes _No
Do you have indigestion or difficulty swallowing? _Yes _No
Have you had an obvious change in a wart or mole? _Yes _No
You have a nagging cough or hoarseness? _Yes _No

Past Medical History:
Have you ever been diagnosed as having or suffered from?:
_Fractured or broken bones _Osteoarthritis _Eating disorder _Circulatory problems _Epilepsy _Alcoholism _Rheumatoid arthritis _Pacemaker _Drug addiction _Seizures _Convulsions _Strokes _HIV-positive _Congenital disease _Cancer _Gallbladder _Excessive bleeding _Ruptures _Depression _High/Low blood pressure _Coughing blood _Ulcers

Do you have a history of stroke or hypertension? _Yes _No
Have you been treated for any health condition by a physician in the last year? _Yes _No If yes, describe: _____
What medications or drugs are you taking? _____
Do you have any allergies? _Yes _No If yes, describe: _____
Please list any other health problems you have, no matter how insignificant they may seem: _____

Social history:
Do you drink alcohol? If so, how much per week? _____
Do you use any tobacco products? Do you smoke? _Yes _No If so, packs per day:
Do you take vitamin supplements? _Yes _No If so, please list: _____
Do you consume caffeine? If so, how much per day: _____
Do you exercise? If yes, what is the frequency and type of exercise?_____
What are your hobbies? _____
What activities do you routinely do throughout the day?: _Lifting _Sitting _Bending _Working at computer _Other_____

Have you had previous chiropractic care before? _Yes _No
If yes, when was your last treatment? _____
What is your goal from our treatment? _ Some relief and then on my own _No pain and then on my own __No pain and spinal wellness that prevents relapses

Authorization and release: I understand that the responsibility for payment of service is ultimately mine and that Johannes Chiropractic Office is assisting me with the insurance processing. I authorize payment of insurance benefits directly to Johannes Chiropractic Office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient signature: _____Date: _____
Guardian signature authorizing care: _____Date: _____

Johannes Chiropractic Office
4864 Buffalo Road, Erie, PA 16510-814-899-5400 Fax: 814-899-6981

INFORMED CONSENT

Name: _____
Please Print Patient Name

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of ancillary therapy on me (or the patient named below, for whom I am legally responsible) by Dr. James G. Johannes or other licensed doctors of chiropractic now or in the future who work in the clinic or office listed below.

I have had the opportunity to discuss with Dr. Johannes and/or 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 there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations, and sprains. I do not expect Dr. Johannes 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 on the facts been known to him or her, is in my best interest.

I have read, or have had read to me, or have had explained 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 form to cover the entire course of treatment for my present condition for any future condition(s) for which I seek treatment.

Patient Signature_____ Date_____

HIPAA

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for use of Health Information.

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Patient Signature_____ Date_____

If patient is a minor or under a guardianship order as defined by state law:

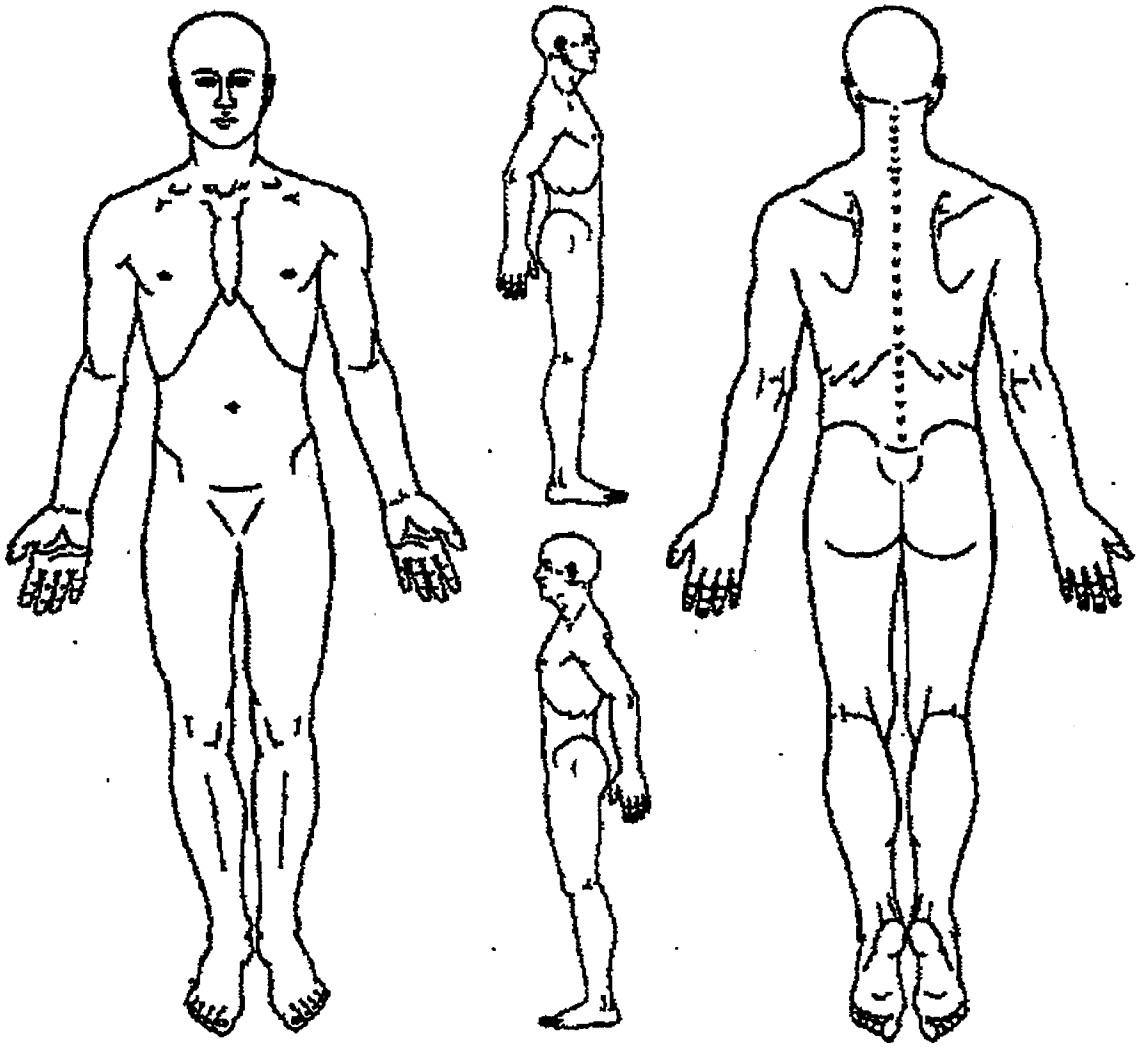
By_____
Signature of Parent / Guardian (Circle One)

Name:_____ Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score