PEDIATRIC

TRENTON L. JOHNS, PLLC

HISTORY FORM

Name:________________________________ DOB:______________ Date:______________ File#:_______

PATIENT INFORMATION

Date _____/_____/_____

Full Name: ____

Address: ____

City: ____________________________ State: _____ Zip: ________

Date of Birth: _____/_____/_____ Sex: M F Age: _______

Social Security #: ______________________________________

School: ____

School Address: ____

City: ____________________________ State: _____ Zip: ________

Parent/Guardian Name: ___________________________________

❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Occupation: ____

❒ Full-time ❒ Part-time ❒ Unemployed ❒ Retired

Parent/Guardian Date of Birth: _____/_____/_____

Spouse's Name: ____

How did you hear about us?

____

PAYMENT INFORMATION

Who is responsible for this account? _________________________

Relationship to patient? ___________________________________

Will you be using insurance? ❒ Yes ❒ No

Insurance Company: ______________________________________

Policy #: ____

Group #: ____

(We need a copy of your insurance card for our records)

***Date of Birth of Policy Holder:** _____/_____/_____

(We must have his in order to check your insurance benefits)

ASSIGNMENT & RELEASE AGREEMENT:

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to Trenton L. Johns, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. 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. I authorize the use of this signature on all insurance submissions.

______________________________ ____________

Signature *Date*

CONTACT INFORMATION

Home: (_____) _____-________ **Work:** (_____) _____-_______ Ext: ______ **Cell:** (_____) _____-________

I give permission for you to: ☐ Contact me at work ☐ Leave a message on my answering machine

E-mail Address: ____

IN CASE OF EMERGENCY, CONTACT:

Name: ______________________________ Relationship: ______________________

Home: (______) ______-______ Work: (______) ______-______ Ext: ______ Cell: (______) ______-______

OTHER DOCTORS

Previous Chiropractor: ___________________________________

City: ____

Date of Last Visit: ______________________________________

Reason for Leaving: _____________________________________

Family Physician/Primary Care Provider:

____

City: ____

HIPPA WAIVER

Trenton L. Johns, PLLC use a sign in sheet and your name will be visible for others to see when you are present. By signing this waiver you give Trenton L. Johns, PLLC permission to utilize this system.

______________________________ ____________

Signature *Date*

TRENTON L. JOHNS, PLLC *HISTORY FORM*

Name:____________________ DOB:__________ Date:__________ File#:_______

PATIENT CONDITION

Major Problem: ____

____

When did your symptoms appear? ____________________

What caused this condition? ____________________

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

Rate the severity of your pain (10 = severe): 1 2 3 4 5 6 7 8 9 10

Describe the pain: ❒ Sharp ❒ Dull ❒ Throbbing ❒ Numbness ❒ Aching ❒ Shooting

❒ Burning ❒ Tingling ❒ Cramps ❒ Stiffness ❒ Swelling ❒ Other: __________

How often is this pain noticed? ❒ Constantly ❒ Frequently ❒ Occasionally ❒ Intermittently
(% of day): (100-76%) (75-51%) (50-26%) (25-1%)

How long do the symptoms last? ____________________

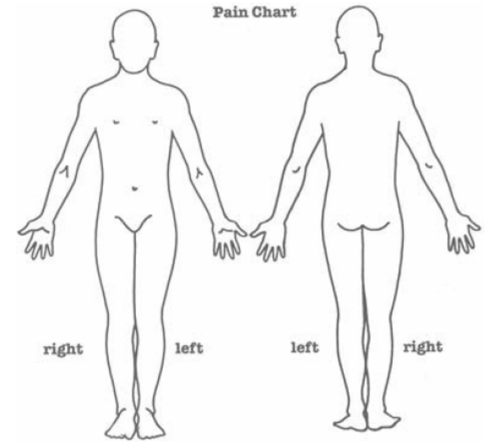
Activities or movements that are painful to perform:
❒ Sitting ❒ Standing ❒ Walking ❒ Bending ❒ Lying Down ❒ Other: __________

What makes it worse? ____________________

What makes it better? ____________________

This problem could be due to: ❒ Auto Accident ❒ Work Injury

How committed are you to helping us solve this problem? (Scale of 1-10): ________



(Mark the picture above where you are feeling pain)

How does this problem interfere with your:

Play: ____________________

Family: ____________________

Hobbies: ____________________

Sleep: ____________________

HEALTH HISTORY

Injuries/Surgeries you have had:		Description	Date
Auto	❒ Yes ❒ No	____________________	___/___/___
Slips/Falls	❒ Yes ❒ No	____________________	___/___/___
Broken Bones	❒ Yes ❒ No	____________________	___/___/___
Surgeries	❒ Yes ❒ No	____________________	___/___/___
Vaccinations	❒ Yes ❒ No	____________________	___/___/___

Other Physician's consulted for this condition: ____________________

Mark any methods you have tried to treat this condition: ❒ Ice ❒ Dry Heat ❒ Moist Heat ❒ Stretching ❒ Massage
❒ Physical Therapy ❒ Bed Rest ❒ Medications ❒ Other: __________

Results from treatments: ____________________

All medications you are currently taking: For what?

____________________ __________

____________________ __________

____________________ __________

____________________ __________

Please mark the details of the birth process:

❒ Midwife ❒ Hospital ❒ Obstetrician

❒ Vaginal ❒ C-Section ❒ Forceps ❒ Vacuum Extraction

❒ Induced ❒ Epidural ❒ Obstetrician

❒ Breastfeed ❒ Formula APGAR Score: __________

EXERCISE	PLAY ACTIVITY	HABITS	
❒ None	❒ None/Low Intensity	❒ Candy	Pieces/Day: __________
❒ Moderate	❒ Moderate Intensity	❒ Soda	Drinks/Week: __________
❒ Daily	❒ High Intensity	❒ Falls	Falls/Week: __________
❒ Heavy	❒ Sports: __________	❒ High Stress Level	Reason: __________

TRENTON L. JOHNS, PLLC *HISTORY FORM*

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PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

❒ AIDS/HIV
❒ Allergies
❒ Anemia
❒ Anorexia
❒ Appendicitis
❒ Ashma
❒ Bed Wetting
❒ Bleeding Disorder
❒ Bronchitis
❒ Cancer
❒ Chicken Pox
❒ Colic
❒ Constipation
❒ Diarrhea
❒ Dizziness
❒ Ear Infections
❒ Epilepsy
❒ Frequent Colds/Flu
❒ Heart Disease
❒ Hepatitis
❒ Measles
❒ Migraine Headaches
❒ Mononucleosis
❒ Multiple Sclerosis
❒ Mumps
❒ Numbness Arms/Hands/Legs
❒ Pneumonia
❒ Polio
❒ Psychiatric Care
❒ Rheumatic Fever

Please list any other health problems you have, no matter how insignificant they may be:

____

____

FAMILY HISTORY

Please indicate which conditions have been experienced by your family members by marking appropriate boxes (**M**=Mother & **F**=Father)

Father: living deceased COD: ___________________________ **Mother**: living deceased COD: ___________________________

❒ Cancer ______________________
❒ Diabetes
❒ Stroke
❒ Heart Attack/Disease
❒ Thyroid Disease
❒ Tuberculosis
❒ Mental Illness
❒ Kidney Disease
❒ Lung Disease
❒ Liver Disease
❒ Asthma
❒ Arthritis
❒ Epilepsy
❒ Other: ______________________
❒ Other: ______________________

Doctor's Notes: ____

____

____

____

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____

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____

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TRENTON L. JOHNS, PLLC *HISTORY FORM*

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REVIEW OF SYSTEMS

Please **check Yes or No** to indicate if you currently have any problems in one or more of the following areas? If yes, please explain.

SYSTEM	EXAMPLES	YES/NO	DESCRIPTION
GENERAL/CONSTITUTIONAL	Tired feeling Headaches/Migraines Fever Weight loss/gain	❒ Yes ❒ No	
EYES	Vision problems Blurred vision Eye pain Eye discharge	❒ Yes ❒ No	
EARS, NOSE, THROAT, MOUTH	Hearing loss Ear ache Nasal congestion, Chronic cough Dry mouth Allergies/Hay fever	❒ Yes ❒ No	
RESPIRATORY	Asthma Emphysema Chronic bronchitis Wheezing Shortness of breath	❒ Yes ❒ No	
CARDIOVASCULAR	Diabetes Hypertension Heart problems	❒ Yes ❒ No	
GASTROINTESTINAL	Acid Reflux/Heartburn Diarrhea or Constipation Gas or Belching Hernia Ulcers	❒ Yes ❒ No	
GENITOURINARY	Painful urination Frequent urination Loss of control Impotence Jaundice	❒ Yes ❒ No	
LYMPHATIC	Anemia Bleeding problems Blood transfusions Swelling	❒ Yes ❒ No	
MUSCULOSKELETAL	Arthritis Joint/ Muscle pain Cramps Stiffness Swelling	❒ Yes ❒ No	
SKIN	Pimples Warts/Growths Rashes Dryness/Itch	❒ Yes ❒ No	

____ ________________

Signature *Date*

Name:_________________________ DOB:____________ Date:____________ File#:_______

TERMS OF ACCEPTANCE:

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.
Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Chiropractic adjustments are exceedingly safe when applied properly; however, all actions in life come with some risk, including chiropractic adjustments. Although the risks are minimal, there have been rare reports of vertebral artery damage, fractures and aggravation of disc conditions associated with chiropractic procedures. A small force is introduced into the spine during an adjustment that may result in minor temporary musculoskeletal discomfort. I am invited to ask any questions or express any concerns that I may have. I am free to withdraw my consent and discontinue care at any time.

MEDICAL RELEASE

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.

ASSIGNMENT OF BENEFITS

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, I hereby assign any such company (the pertinent data below) and authorize you to comprise, settle, or otherwise resolve this claim as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company/companies contractually obligated, you will understand that whatever amounts you do not collect from insurance proceeds (whether it be part or all of what is due), I personally owe you.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and I give my permission to perform an x-ray examination. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: ______________ Initial: ________

CONSENT TO TREAT

I understand that if I am accepted as a patient by Dr. Johns, I am authorizing Trenton L. Johns, PLLC to proceed with any treatment that may be necessary. By signing below I verify that I have read and understood the content of this form and give my consent to be treated in this office. A photocopy of this assignment shall be valid and have the same effect as the original.

_________________________ _______________ _________________________

Signature *Date* *Staff Witness*

Name:________________________________ DOB:______________ Date:______________ File#:_______

NOTICE OF PRIVACY POLICY

We are committed to upholding the security and confidentiality of personal information you provide to us. This policy covers patient information, including personal and health information. We are disclosing this policy as required by federal Health Insurance Portability and Accountability Act (HIPPA) regulations.

Information we may collect:
In order to provide you with appropriate chiropractic services and to better serve you, we collect:
1. Information we receive from you on forms
2. Information about your treatments with us or with other physicians with whom we are working in conjunction regarding your health.

Information we share with affiliates:
No non-public personal health information about patients or former patients is shared with affiliates beyond what is necessary to provide you appropriate chiropractic services or as permitted by law. Trenton L. Johns, PLLC or Trinity Chiropractic may, with notice given to the patient, deliver personal, non-public health information to another physician for consultation and/or referral.

Information we share with non-affiliated third parties:
Trenton L. Johns, PLLC has no non-affiliated third parties with which we share non-public personally identifiable information. We do not sell client information or provide patient information to persons or organizations outside of this office.

Necessary disclosures of information:
We may disclose any information we collect when permitted or required by law. This may include, but is not limited to, disclosures related to a court subpoena or other similar legal requests, fraud investigations, or an audit or security examination.

Protecting patient information:
We limit access to non-public patient information to those employees of Trenton L. Johns, PLLC who need to know the information to provide proper chiropractic and health services to you. We maintain physical, electronic, and procedural safeguards that comply with regulations to protect your non-public personal information.

Accuracy of account information:
It is very important that YOU, as a patient, help us keep our information about your health up-to-date and accurate. You have access to your account information through EOB's (Explanation of Benefits) and also through review of your chiropractic chart within the confines of this office. In most cases, Trenton L. Johns, PLLC receives account information directly from your insurance provider or other payer source. If you believe that we may not have your updated information, first verify that your insurance provider or other payer source has the most current information.

If, after reading this notice, you have questions or concerns please let us know.

NOTICE OF RECEIPT OF PRIVACY POLICY

I do hereby acknowledge that I have read the foregoing document. By signing my name below I am indicating that I understand the Privacy Policy enacted by Trenton L. Johns, PLLC which stipulates that my personal health information cannot be released to any third party without my express consent, whether verbal or written.

_______________________________________ _______________________________

Signature *Date*