

Name: _____ DOB: _____ Date: _____ File#: _____

IT IS NECESSARY THAT IF YOUR INJURIES ARE DUE TO AN AUTOMOBILE ACCIDENT THAT WE ARE GIVEN THE FOLLOWING INFORMATION WITHIN YOUR FIRST TWO VISITS OR YOU MAY BECOME RESPONSIBLE FOR ANY CHARGES INCURRED. THANK YOU.

We need the following:

1 Insurance Name: _____

2 Insurance Address: _____

3 Insurance Phone Number: _____

4 Claim Number: _____

5 Name of Adjuster: _____

6 Copy of Police Report

The above information is necessary to verify that personal injury protection (PIP) insurance will cover your chiropractic expenses.

You must file a claim with your insurance company. The State of Kentucky is a NO FAULT state and therefore you are required to file a claim with YOUR INSURANCE COMPANY, whether the accident was your fault or not. After you have called your insurance company and filed a claim, complete this form and give it to the receptionist in our office. Our office will call the insurance company and verify PIP coverage and whether or not you have an active claim. They will not verify to us at anytime what benefits you have or have left on a particular claim. You will be instructed to call your insurance company periodically to be updated on the amount of PIP coverage used and what is left. If we receive claims back that are not covered due to exhaustion of PIP benefits we will notify you promptly. You will also receive information concerning your PIP benefits and are asked to promptly notify our office of any questions or end of PIP benefits.

If you have any questions on the above procedure, our chiropractic insurance administrator will be glad to assist you. Thank you for your cooperation.

~ Trenton L. Johns, D.C.

Trenton L. Johns, PLLC

10101 Taylorsville Rd. Louisville, KY 40299
Phone: (502)-267-3040 Fax: (502)-267-9019

Name: _____ DOB: _____ Date: _____ File#: _____

PATIENT INFORMATION

INSURANCE & ATTORNEY INFORMATION

Date ____/____/____
 Full Name: _____
 Address: _____
 City: _____ State: ____ Zip: _____
 Date of Birth: ____/____/____ Sex: M F Age: _____
 Social Security #: _____
 Occupation: _____
 Full-time Part-time Unemployed Retired
 Employer: _____
 Single Married Widowed Separated Divorced
 Spouse's Name: _____
 Spouse's Occupation: _____
 Spouse's Employer: _____
 Number of Children: _____

Children's Names	Ages
_____	_____
_____	_____
_____	_____

How did you hear about us?

Insurance Company: _____
 Claim #: _____
 Have you retained an attorney?: Yes No
 Name of Attorney: _____
 Address of Attorney: _____

 Attorney Phone #: _____

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

HIPPA WAIVER

Previous Chiropractor: _____
 City: _____
 Date of Last Visit: _____
 Reason for Leaving: _____
 Family Physician/Primary Care Provider:

 City: _____

Trenton L. Johns, PLLC uses 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

Name: _____ DOB: _____ Date: _____ File#: _____

ACCIDENT HISTORY

Vehicles Involved:

Your Vehicle

Other Vehicle

Year: _____ Year: _____ Date of Accident: _____
 Make: _____ Make: _____ Time of Accident: _____ AM PM
 Model: _____ Model: _____ Location of Accident: _____
 Speed: _____ Speed: _____
 Size: Small Mid Large Size: Small Mid Large

Accident Type: Rear-ended Head-on Broad-sided

Describe the accident (in detail): _____

Specifics of the accident:

Were you the: Driver Passenger
 Sitting in the: Front Seat Back Seat
 Were you wearing a seatbelt?: Yes No
 Did the airbag deploy?: Yes No
 Did the impact surprise you?: Yes No
 Were you facing forward? Yes No _____
 Did you brace for the impact? Yes No
 Did your head strike an object? Yes _____ No
 Position of the headrest to head? High Middle Low
 Did you experience any: Loss of Consciousness Nausea/Vomiting
 Dizziness Bleeding
 Go into shock Flash of light seen upon impact

The road was:

Dry Wet
 Icy Snowy

The weather condition was:

Sunny Light Rain
 Cloudy Heavy Rain
 Foggy Snowing

Did you feel pain immediately following the accident?

Yes No

Immediately following the accident:

Ambulance/Paramedics were called to the scene _____
 Treated at the scene _____
 Transported to the Hospital by Ambulance _____
 Went to the Hospital on my own _____
 Diagnostics were performed at the Hospital _____
 Medication was prescribed _____
 Treatment at Hospital _____
 Follow-up was recommended _____

State your emotions and physical state immediately following the accident: _____

Time Loss: Have you had any missed work due to injuries from the accident? Yes No

How long have you been off work?: _____ days weeks months

Do you work with limitations? Yes No What limitations?: _____

Name: _____ DOB: _____ Date: _____ File#: _____

PATIENT CONDITION

Please describe only one area at a time from most severe to least severe (ex: neck, mid-back, low back)

Primary problem: _____

Where is the pain? _____

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%) (75%) (50%) (25%)

How long do the symptoms last? _____ seconds minutes hours days weeks

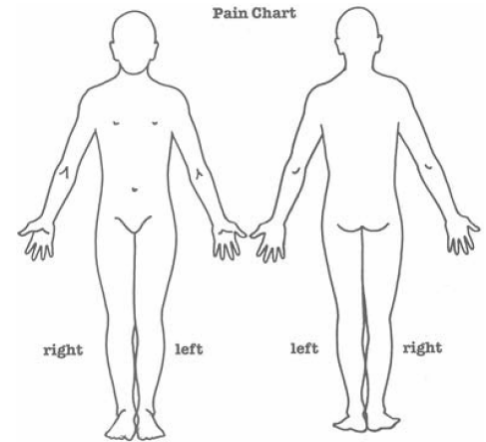
Does this condition radiate/refer to other areas? _____

What makes it worse? _____

What makes it better? _____

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

Is there anything else I should know about this problem? _____



(Mark the picture above where you are feeling pain)

- Aching Pain
- Sharp Pain
- Burning Pain
- X Numbness/Tingling

PATIENT CONDITION

Please describe only one area at a time (ex: neck, mid-back, low back)

Secondary problem: _____

Where is the pain? _____

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%) (75%) (50%) (25%)

How long do the symptoms last? _____ seconds minutes hours days weeks

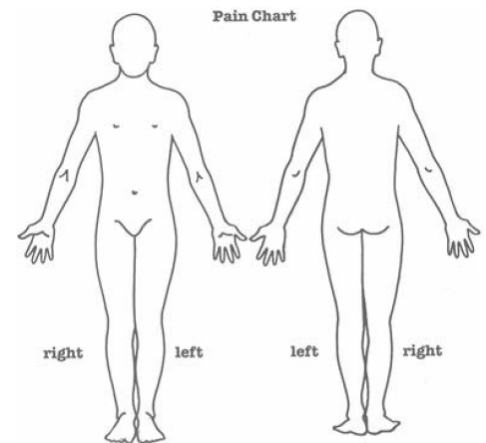
Does this condition radiate/refer to other areas? _____

What makes it worse? _____

What makes it better? _____

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

Is there anything else I should know about this problem? _____



(Mark the picture above where you are feeling pain)

- Aching Pain
- Sharp Pain
- Burning Pain
- X Numbness/Tingling

**If you need additional sheets, please ask.*

Dr.'s Initials: _____

Name: _____ DOB: _____ Date: _____ File#: _____

HEALTH HISTORY

Injuries/Surgeries you have had:	Description	Date
Auto <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Slips/Falls <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Broken Bones <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Additional:	_____	____/____/____

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?	Facility of your last:	Date
_____	_____	X-RAY _____	_____
_____	_____	MRI _____	_____
_____	_____	CT _____	_____
_____	_____	BONE SCAN _____	_____

PAST MEDICAL HISTORY

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

- | | | |
|--|---|---|
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Congenital Disease _____ |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Coughing Blood |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hernia _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Depression |

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: _____

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Attack/Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other: _____ |

Name: _____ DOB: _____ Date: _____ File#: _____

DAILY ACTIVITIES

Please mark each that applies to your daily activities due to the problem(s):

- Stays home most of the time.
- Stays in bed most of the day.
- Has difficulty turning over in bed.
- Has to lie down to rest frequently.
- Changes position frequently to try to get comfortable.
- Does not do jobs around the house.
- Walks more slowly than usual.
- Can only walk short distances.
- Has difficulty climbing stairs.
- Has to use handrails to get up stairs, etc.
- Has difficulty bending/kneeling.
- Can only stand for short periods of time.
- Has to sit most of the day.
- Has to hold onto something to sit/stand from a chair.
- Has to get other people to do things for you.
- Has difficulty getting dressed.
- Has to get dressed with someone's help.
- Has a loss of appetite.
- Has difficulty sleeping.
- Other: _____
- Other: _____

List all recreational activities that you are unable to perform to the same extent due to the problem.

How often do you have to stop activities and sit/lie down due to the problem(s)?

- All day
- Several times a day
- Occasionally
- Approximately once per day
- Never

How does this problem interfere with your:

Work: _____

Family: _____

Hobbies: _____

Sleep: _____ Hours/night: _____

EXERCISE

- None _____
 - Moderate _____
 - Daily _____
 - Heavy _____
- Type: Aerobic Weight lifting Run/Jog Walk
- Yoga Other: _____

SOCIAL HISTORY

- Smoking Packs/Day: _____
- Alcohol Drinks/Week: _____
- Coffee/Caffeine Drinks Cups/Day: _____
- Drugs Type: _____
- Sex Activity: Limited? Painful? Difficult? Normal?
- High Stress Level Reason: _____

OCCUPATIONAL HISTORY

Your Employer: _____

Job Title: _____

Highest level of education attained: _____

Work Activity:

- Sitting
- Standing
- Light Labor
- Heavy Labor

Job Satisfaction:

- Very Satisfied
- Satisfied
- Dissatisfied
- Very Dissatisfied

Name: _____ DOB: _____ Date: _____ File#: _____

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

WOMEN: Date of last menses: ____/____/____ # of days in cycle: _____ Are you pregnant? Yes No Unsure

Signature

Date

Name: _____ DOB: _____ Date: _____ File#: _____

Functional Rating Index

For use with Neck and/or Back problems only

In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0. No pain
1. Mild pain
2. Moderate pain
3. Severe pain
4. Worse pain possible

2. Sleeping

0. Perfect sleep
1. Mildly disturbed sleep
2. Moderately disturbed sleep
3. Severely disturbed sleep
4. Totally disturbed sleep

3. Personal Care (wash, dress, etc)

0. No pain; No restrictions
1. Mild pain; No restrictions
2. Moderate pain; Need to go slow
3. Moderate pain; Need some assistance
4. Severe pain; Need 100% assistance

4. Travelling (driving, etc.)

0. No pain on long trips
1. Mild pain on long trips
2. Moderate pain on long trips
3. Moderate pain on short trips
4. Severe pain on short trips

5. Work

0. Can do usual work + unlimited extra work
1. Can do usual work; No extra work
2. Can do 50% of usual work
3. Can do 25% of usual work
4. Cannot work

6. Recreation

0. Can do all activities
1. Can do most activities
2. Can do some activities
3. Can do a few activities
4. Cannot do any activity

7. Frequency of Pain

0. No pain
1. Occasional pain; 25% of the day
2. Intermittent pain; 50% of the day
3. Frequent pain; 75% of the day
4. Constant pain; 100% of the day

8. Lifting

0. No pain with heavy weight
1. Increased pain with heavy weight
2. Increased pain with moderate weight
3. Increased pain with light weight
4. Increased pain with any weight

9. Walking

0. No pain any distance
1. Increased pain after 1 mile
2. Increased pain after ½ mile
3. Increased pain after ¼ mile
4. Increased pain with all walking

10. Standing

0. No pain after several hours
1. Increased pain after several hours
2. Increased pain after 1 hour
3. Increased pain after ½ hour
4. Increased pain with any standing

 Patient's Signature

 Date

TOTAL SCORE: _____ / 40

Dr.'s Initials: _____

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

Dr.’s Initials: _____

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*

