JOHNSTONE CHIROPRACTIC

Dr Jeremy S. Johnstone DC
515 SR 9 NE, Suite 105, Lake Stevens, WA 98258

Chart # _____

Welcome

PATIENT INFORMATION

Date _____

Name _____

Mailing Address _____

Home Phone _____ Cell _____

Sex ☐M ☐F Age _____ Birth Date _____

Single / Married / Divorced / Seperated / Widowed

Employer _____

☐Full Time / ☐Part Time ☐Retired / ☐Unemployed

Work Phone _____ Ext _____

Spouse / Parent Information

Name _____

Employer _____

Work Phone _____ Ext _____

Emergency contact person

_____ _____
Name Relationship

Home Phone _____

Work Phone _____ Ext _____

PATIENT CONDITION

Reason for visit _____

When did condition begin? _____

Has this condition ☐gotten worse ☐stayed the same ☐comes and goes

Has this condition occurred before? ☐Yes ☐No

Other doctors seen for this condition? ☐Yes ☐No

Dr.'s Name _____

Date of last x-ray _____

Is condition related to an accident? ☐Yes ☐No

Date of accident _____

Type of accident ☐Auto ☐Work ☐Home ☐Other

If job related, have you reported the accident to your employer? ☐Yes ☐No

Do you have an attorney? ☐Yes ☐No

Attorney Name _____

Attorney Phone # _____

Who referred you to our office? _____

Have you been to a Chiropractor before? ☐Yes ☐No

INSURANCE INFORMATION

Primary Insurance _____

Insurance ID # _____

Insurance Phone # _____

Group # _____

Name of Insured _____

Insured Birth Date _____ Relationship _____

Address of Insured _____

Secondary Insurance _____

Insurance ID # _____

Insurance Phone # _____

Group # _____

Name of Insured _____

Insured Birth Date _____ Relationship _____

Address of Insured _____

Auto Accident Insurance Information

Your Auto Insurance Co _____

Your Auto Insurance Co Phone # _____

Do you have PIP coverage? ☐Yes ☐No

PIP Insurance Claim # _____

At Fault Insurance Co _____

At fault Insurance Co Phone # _____

Insurance Claim # _____

I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payments of the insurance benefits. I authorize the use of this signature on all insurance submissions.

_____
Signature of Responsible Party

Relationship _____ Date _____

Johnstone Chiropractic *(425) 334-1874*

HEALTH CONDITIONS

Please check each of the conditions or diseases that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- ☐ Severe or frequent headaches
- ☐ Sinus problems
- ☐ Dizziness
- ☐ Loss of Sleep
- ☐ Pain between the shoulders
- ☐ Frequent Neck Pain
- ☐ Numbness or Pain in Arms, Hands, or Legs
- ☐ Lower Back Problems
- ☐ Digestive Problems
- ☐ Difficulty Breathing
- ☐ Heart Attack ☐ Stroke (Date: _____)
- ☐ Heart Murmur
- ☐ Heart Surgery (Date: _____) ☐ Pacemaker
- ☐ Asthma
- ☐ Arthritis
- ☐ Anemia
- ☐ Cancer (please specify: _____)
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Ulcer ☐ Colitis
- ☐ Kidney Problems
- ☐ Thyroid Problems
- ☐ Psychiatric Problems
- ☐ Congenital Heart Defect
- ☐ High ☐ Low Blood Pressure

HEALTH HABITS

(Please circle)

Tobacco use:	☐yes / no☐
Alcohol consumption:	☐yes / no☐
Coffee consumption:	☐yes / no☐
Exercise regularly:	☐yes / no☐

WOMEN

Pregnant:	☐yes / no☐
Nursing:	☐yes / no☐
Taking birth control:	☐yes / no☐
Irregular menstrual cycles:	☐yes / no☐
Painful menstrual cycles:	☐yes / no☐

MEDICATIONS

_____ _____

_____ _____

_____ _____

I hearby authorize the doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred on my behalf at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hearby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____ _____

Patient Signature Date Parent/Guardian/Spouse Signature Date

JOHNSTONE CHIROPRACTIC
Office (425) 334-1874 Dr. Jeremy S. Johnstone DC Fax (425) 334-3852

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

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 or correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. 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.

I, _____ have read and fully understand the above statements.
(Please print your name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have fully read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____

_____ _____
(Signature) (Date)

515 SR 9 Suite 105 Lake Stevens, WA 98258

JOHNSTONE CHIROPRACTIC
515 SR 9 NE, SUITE 105
LAKE STEVENS, WA 98258

Personal Injury Insurance Information

Date of accident: _____

Who caused the accident? _____

Where did the accident happen? (Include address)

_____

_____

What is the at-fault party's address?

_____

_____

The following information is needed of the **at fault party's insurance:** what is the insurance company name, phone number, address, and what is the claim#, and name Of the adjustor managing the claim?

_____

_____

_____

The following information is needed of **your car insurance:** what is the insurance Company name, phone number, and address, and what is the claim#, and the name Of the adjuster managing the claim?

_____

_____

_____

Do you have an attorney who specializes in Personal Injury cases? _____

What is the name, phone number, and address of your attorney?

_____

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Whiplash, Spinal Trauma, and the Personal Injury Case p. 374, 1999 Adler Giersch, P.S.

MECHANISM OF INJURY QUESTIONNAIRE

NAME: _____ Date of Accident: _____
Time: _____

Place: _____

Intersecting with: _____
Police Investigation by: ☐Washington State Patrol ☐City Police ☐County Police
☐Other ☐No Investigation
Road conditions at time of accident: ☐Wet ☐Dry ☐Icy
☐Other - describe _____

Where were you seated in the vehicle? _____
Were you aware of the approaching collision prior to impact or did the impact catch you by surprise? _____
Did you lose consciousness (blackout) upon impact? _____
If yes, can you estimate for how long? _____
Were you struck from: ☐Behind ☐Front ☐Left side ☐Right side
Were you wearing a seat belt? ☐Yes ☐No
If so, what type? ☐Lap belt only ☐Shoulder and lap belt
Is your car equipped with an air bag? ☐Yes ☐No
If so, did it activate? ☐Yes ☐No
Was your car stopped at the time of impact? ☐Yes ☐No
If no, estimate the speed of your vehicle: _____ mph
If your vehicle was moving at the time of impact, was it slowing down? ☐Yes ☐No
If no, was your vehicle gaining speed? ☐Yes ☐No
Number of people in your vehicle: _____ (includes yourself)
Please describe, to the best of your knowledge, how the accident occurred:

_____

_____

_____

What type of car were you in? (Year/make/model): _____

What type of car impacted with your vehicle? (Year/make/model): _____
Was the other vehicle moving at the time of the collision? ☐Yes ☐No
If yes, what was its approximate speed? Approximately _____ mph

If the other vehicle was moving at the time of collision, was it slowing down, gaining speed, or traveling at a steady speed? Slowing down Gaining speed Steady speed

What bruises or cuts did you get from this accident?_____

On what part of the automobile did the following body parts hit?

A. Head hit _____
B. Chest hit_____
C. Right/left shoulder hit _____
D. Right/left arm hit _____
E. Right/left hip hit _____
F. Right/left leg hit _____
G. Right/left knee hit _____
H. Other _____

What position was your head facing upon impact? _____

Was your vehicle pushed forward from the impact? _____ If yes, how much?

☐More than one car length ☐One-half car length ☐One car length ☐Less than ½ car length

☐Not at all Other_____

Did your car hit anything else after it was hit? _____

What is the cost damage to the vehicle you were in? _____

What of the following car parts broke during the accident?

☐A. Windshield ☐B. Right/Left side window ☐C. Steering wheel ☐D. Front seat

E. Other _____ F. Other _____

What hurts? _____

_____

When did your pain begin? _____

_____

_____ _____

Patient signature Date

JOHNSTONE CHIROPRACTIC
Dr. Jeremy S. Johnstone DC

Office (425) 334-1874 Fax (425) 334-3852

REVISED OSWESTRY CHRONIC - **LOW BACK** - PAIN DISABILITY QUESTIONNAIRE
Answer each section by circling the ONE CHOICE that most applies to you.

Section 1: Pain intensity
0. I have no pain at the moment.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate, does not vary much.
4. The pain comes and goes and is severe.
5. The pain is unbearable.

Section 2: Personal Care (wash, dress, etc.)
0. My personal care does not cause pain.
1. My personal care causes some pain.
2. I do not change my personal care though it causes increased pain.
3. I have to change my personal care because it causes increased pain.
4. Because of the pain, I am unable to do some of my personal care.
5. Because of the pain, I am unable to do my personal care without help.

Section 3: Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it causes extra pain.
2. I cannot lift heavy weights off of the floor.
3. I cannot lift heavy weights off of the floor, but I can manage if they are conveniently positioned.
4. I cannot lift heavy weights, but I can manage light/med. weights if conveniently positioned.
5. I can lift only very light weights, at most.

Section 4: Walking
0. Pain does not prevent me from walking.
1. Pain prevents me from walking more than 1 mile.
2. Pain prevents me from walking more than ½ mile.
3. Pain prevents me from walking more than 1/4 mil.
4. I can walk only while using a cane or crutches.
5. I am in bed most of the time and have to crawl.

Section 5: Sitting
0. I can sit as long as I like without pain.
1. I can sit in only my favorite chair as long as I like.
2. Pain prevents me from sitting more than one hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 min.
5. Pain prevents me from sitting at all.

Section 6: 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 longer than one hour without increased pain.
3. I cannot stand longer than ½ hour without increased pain.
4. I cannot stand longer than 10 min. without increased pain.
5. I avoid standing because of the increased pain.

Section 7: Sleeping
0. I have no pain sleeping.
1. My sleep is slightly disturbed (1 hour loss).
2. My sleep is mildly disturbed (1-2 hour loss).
3. My sleep is moderately disturbed (2-3 hour loss).
4. My sleep is greatly disturbed (3-5 hour loss)
5. My sleep is completely disturbed (6 hour+ loss).

Section 8: Work
0. I can work as usual.
1. I can do only my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly work at all.
5. I cannot do any work at all.

Section 9: Traveling
0. I have no pain while traveling.
1. I have some pain, but does not worsen with travel.
2. I have extra pain with travel, but it does not compel me to seek alternative forms of travel.
3. Pain compels me to seek other forms of travel.
4. Pain prevents travel, except that done lying down.
5. Pain prevents all forms of travel.

Section 10: Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates, but is overall getting better.
2. My pain is getting better, improvement is slow.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Patient Signature: _____ **Date:** _____

515 Frontier Village Lane Suite 105 Lake Stevens, WA 98258

JOHNSTONE CHIROPRACTIC
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NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Answer each section by circling the ONE CHOICE that most applies to you.

Section 1: Pain intensity
0. I have no pain at the moment.
1. The pain is mild at the moment.
2. The pain is moderate at the moment.
3. The pain is fairly severe at the moment.
4. The pain very severe.
5. The pain is unbearable.

Section 2: Personal Care (wash, dress, etc.)
0. My personal care does not cause pain.
1. My personal care causes some pain.
2. I do not change my personal care though it causes increased pain.
3. I have to change my personal care because it causes increased pain.
4. Because of the pain, I am unable to do some of my personal care.
5. Because of the pain, I am unable to do my personal care without help.

Section 3: Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it causes extra pain.
2. I cannot lift heavy weights off of the floor.
3. I cannot lift heavy weights off of the floor, but I can manage if they are conveniently positioned.
4. I cannot lift heavy weights, but I can manage light/med. weights if conveniently positioned.
5. I can lift only very light weights, at most.

Section 4: Reading
0. Pain does not prevent me from reading.
1. I can read as much as I want with slight pain.
2. I can read as much as I want with moderate pain.
3. I cannot read much because of moderate pain.
4. I cannot read much because of severe pain.
5. I cannot read at all.

Section 5: Headaches
0. I have no headaches.
1. I have slight headaches occasionally.
2. I have moderate headaches occasionally.
3. I have moderate headaches frequently.
4. I have severe headaches frequently.
5. I have headaches almost all of the time.

Section 6: Concentration
0. I can concentrate fully without difficulty.
1. I can concentrate fully with slight difficulty.
2. I concentrate with a fair degree of difficulty.
3. I have a lot of difficulty concentrating.
4. I have a great deal of difficulty concentrating.
5. I cannot concentrate at all.

Section 7: Sleeping
0. I have no pain sleeping.
1. My sleep is slightly disturbed (1 hour loss).
2. My sleep is mildly disturbed (1-2 hour loss).
3. My sleep is moderately disturbed (2-3 hour loss).
4. My sleep is greatly disturbed (3-5 hour loss)
5. My sleep is completely disturbed (6 hour+ loss).

Section 8: Work
0. I can work as usual.
1. I can do only my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly work at all.
5. I cannot do any work at all.

Section 9: Traveling
0. I have no pain while traveling.
1. I have some pain, but does not worsen with travel.
2. I have extra pain with travel, but it does not compel me to seek alternative forms of travel.
3. Pain compels me to seek other forms of travel.
4. Pain prevents travel, except that done lying down.
5. Pain prevents all forms of travel.

Section 10: Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates, but is overall getting better.
2. My pain is getting better, improvement is slow.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Comments:_____

_____

Patient Signature: _____ **Date:** _____

JOHNSTONE CHIROPRACTIC
Dr. Jeremy S. Johnstone DC
Office (425) 334-1874 www.Johnstone.Chirodirectory.com Fax (425) 334-3852

FUNCTIONAL RATING INDEX

For use with **Neck** and/or **Back** Problems.

NAME: _____ Date: _____ Claim#: _____

In order to properly assess your condition, we must understand how much your **neck** and/or **back** problems have 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	1	2	3	4
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleeping

0	1	2	3	4
Perfect Sleep	Mildly Disturbed Sleep	Moderately Disturbed Sleep	Greatly Disturbed Sleep	Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No Pain; No Restrictions	Mild Pain; No Restrictions	Moderate Pain; Need to go slowly	Moderate Pain; Need some assistance	Severe Pain; Need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No Pain on Long Trips	Mild Pain on Long Trips	Moderate Pain on Long Trips	Moderate Pain on Short Trips	Severe Pain on Short Trips

5. Work

0	1	2	3	4
Can do Usual Work Plus Unlimited Extra Work	Can do Usual Work; No Extra Work	Can do 50% of Usual Work	Can do 25% of Usual Work	Cannot Work

See Reverse ---->

 Claim#: _____

6. Recreation

0	1	2	3	4
Can do All Activities	Can do Most Activities	Can do Some Activities	Can do a few Activities	Cannot do any Activities

7. Frequency of Pain

0	1	2	3	4
No Pain	Occasional Pain; 5% of the day	Intermittent Pain; 50% of the day	Frequent Pain; 75% of the day	Constant Pain; 100% of the day

8. Lifting Weights/Objects

0	1	2	3	4
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With any Weight

9. Walking

0	1	2	3	4
No Pain; Any Distance	Increased Pain After 1 Mile	Increased Pain After ½ Mile	Increased Pain After ¼ Mile	Increased Pain With all Walking

10. Standing

0	1	2	3	4
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After 1 Hour	Increased Pain After ½ Hour	Increased Pain With any Standing

_____ Patient Signature

_____ Date

For office use only:

FRI %: _____

CONTRACTUAL GUARANTEE OF PAYMENT FOR HEALTH CARE SERVICES

I hereby authorize and direct you, my attorney, to pay directly to **JOHNSTONE CHIROPRACTIC** such sums as may be due and owing for health care services for injuries arising from a motor vehicle accident. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor or his office. I hereby further consent to a lien being filed on my case by said doctor or his office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempted rescission will not be honored by my attorney. I hereby instruct that in the event another is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor or his office for all health care bills submitted by him for services rendered me. Further, this agreement is made solely for said doctor's additional protection and in consideration for his forbearance on payment. I understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages. **Also, I understand that my responsibility to pay Johnstone Chiropractic's / Dr. Jeremy S. Johnstone's bill is independent and separate from Johnstone Chiropractic's / Dr. Jeremy S. Johnstone's right to file a lien to protect its financial interest.**

I specifically request my attorney to acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payments on a current basis.

_____ _____

Date Signature of Patient

_____ _____

Patient's Driver's License Number Patient's Social Security Number

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor named above.

_____ _____

Date Signature of Attorney

Please date, sign and return one original to:

Johnstone Chiropractic
515 SR 9 NE, Suite 105
Lake Stevens, WA 98258
(425)334-1874 Fax (425)334-3852