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

Dear New Patient:

Welcome to Johannes Chiropractic Office. I realize that entering a new office can be a little scary and a little uncomfortable. My staff and I promise to explain each event as you move through them while at the office. 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 and your health seriously and we cherish your confidence in our care.

You are in the right place, at the right time. We are going to help you get 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
What is your height?___________ What is your weight?___________ (We will certainly check for you if you prefer.)

History of present illness:

Areas of pain: __Neck __Back __Other: _______________________________________
Date symptoms first 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.

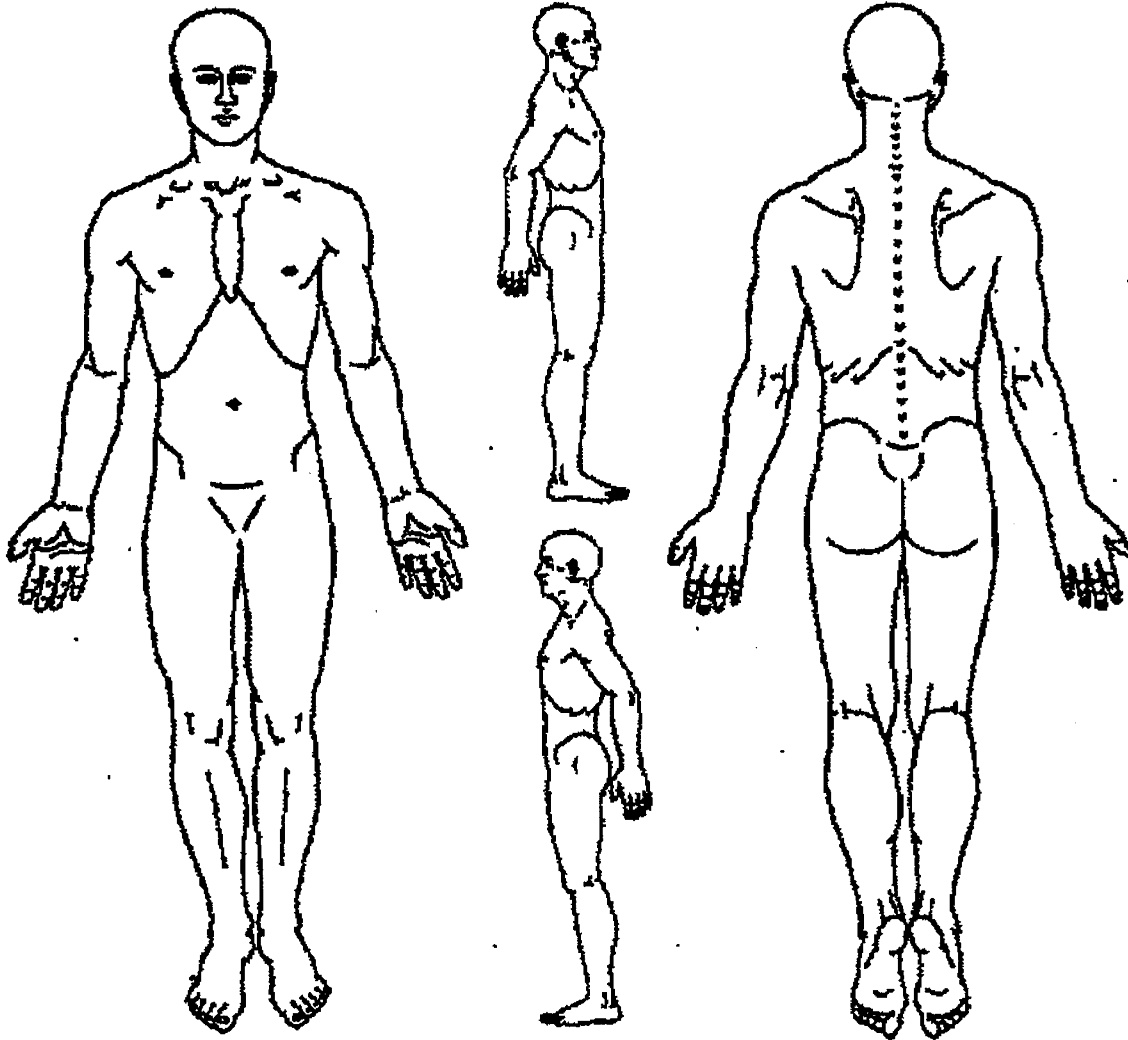
Patient signature: ____________________Date: __________
Guardian signature authorizing care: ____________________Date: __________

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

REVISED OSWESTRY DISABILITY

Name ______________________________ Date____/____/____ File #____________
(Please Print)

This questionnaire helps us to understand how much your low back pain has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

SECTION 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4- Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not, increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing, because it increases the pain immedlatley.

SECTION 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/4.
- ☐ Because of pain, my normal night's sleep is reduced by less than 1/2.
- ☐ Because of pain, my normal nights sleep is reduced by less than 3/4.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Form by N. Hudson- Cook, K. Tomes-Nicholson, A. Breen. In Roland MO, Jenner JR. Eds. Back Pain.
Manchester University Press 1989: 187-204

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.

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.

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).

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.

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.

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.

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.

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.

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.

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.

Neck Index Score

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

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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)