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

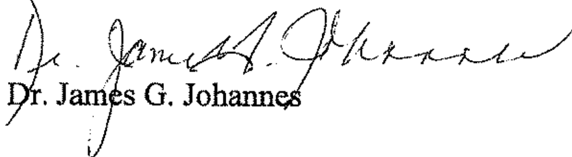
Dear New Patient:

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.

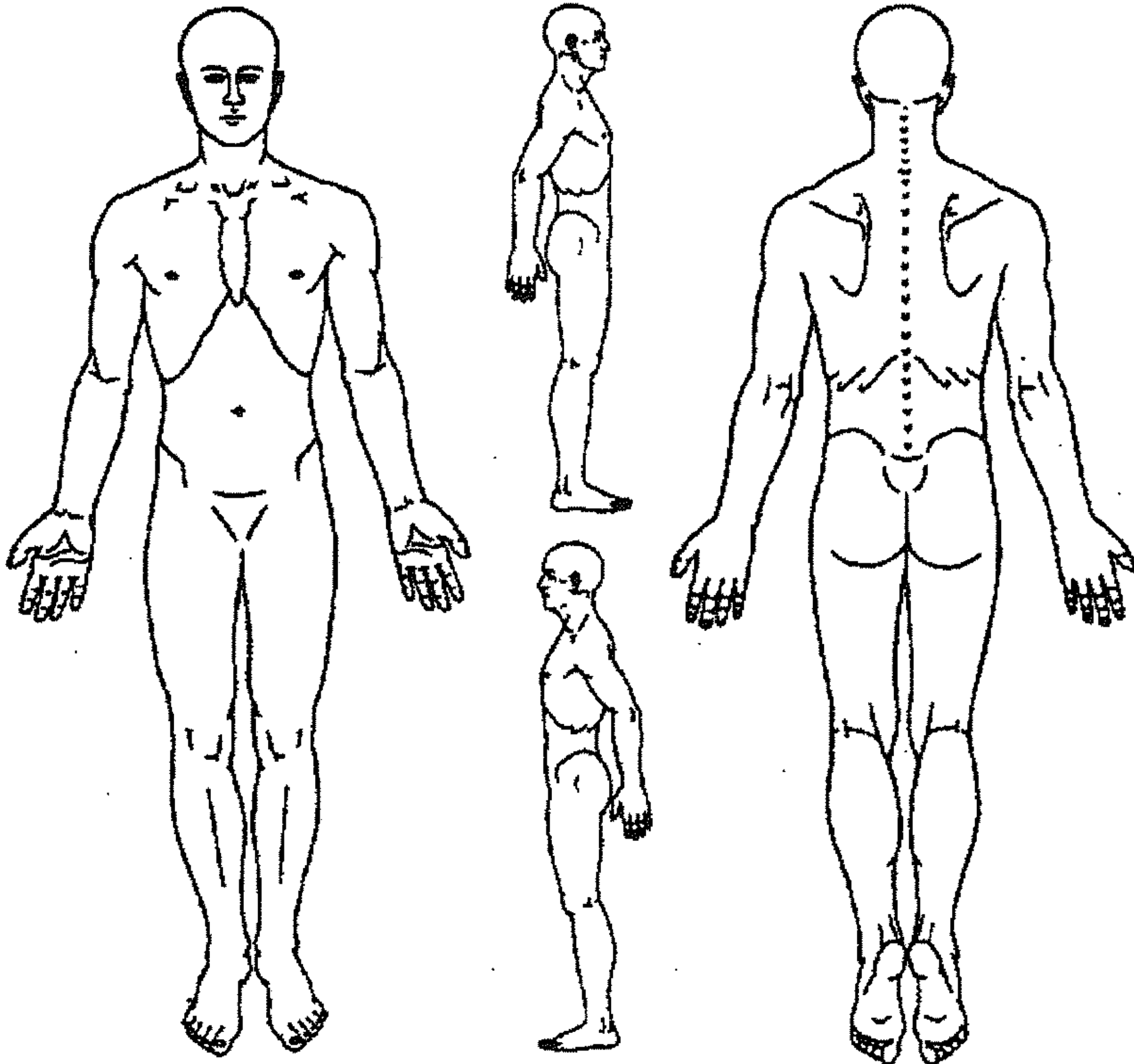
Patient signature: ______________________________Date: __________
Guardian signature authorizing care: ______________________________Date: __________

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

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

Name_______________________________ Date______________

Print Patient's Name

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.

Dated this _______ day of _______________________, 20___

By___________________________________

Patient's Signature

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

By___________________________________

Signature of Parent/Guardian (circle one)

Informed Consent

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_________

Witness signature____________________________ Date_________

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

Patient's Name______________________________ Number__________ Date______________

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

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

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

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, but I can manage if they are conveniently positioned, for example 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 lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = ___________ %ADL______

Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Comments______________________________
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

Patient's Name________________________ Number__________ Date__________

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

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

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

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, but I can manage if they are conveniently positioned, for example 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 lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 -- Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = __________ %ADL

Section 6 -- Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 -- Social Life

☐ My social life is normal and gives me no extra 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.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 -- Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

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 at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments________________________

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204