Pt. # _____

Confidential Health Information

Date: _____

Last Name: _____ First Name: _____

Male ☐ Female ☐ SSN: _____-_____-_____ DOB: ___/___/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Home phone: _____

Cell Phone: _____ May we text you? _____ Work phone: _____

May we contact you at work: _____ Preferred method of contact: _____

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Spouse/ Partner Name: _____ Phone Number: _____

Do you have children? _____ List their names and ages: _____

Your occupation: _____ Your employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Whom may we thank for referring you to our office? _____

Have you consulted a chiropractor before? _____ If so, whom? _____

When was the last time your spouse/ children/ partner had their spines checked? _____

Your primary care physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

When was your last visit to your PCP? _____ May we contact them if needed? _____

Insurance company: _____ Policy #: _____ Group #: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Insured's name: _____ Insured's DOB: _____

Who's policy? Self ☐ Spouse ☐ Insured's Employer: _____ Phone: _____

Insured's Employer address: _____ City: _____ State: _____ Zip: _____

Jones Chiropractic Clinic
801 E. Watauga Ave
Johnson City, TN 37601
Dr. Jones Dr. Hicks Dr. Carruthers
Joneschiroclinic@gmail.com

Total Health and Wellness
801 E. Watauga Ave.
Johnson City, TN 37601
Linda Holmes, FNP-BC Caiti Riden, FNP-C
Livvy Weaver, FNP-C

_____
Doctor's Initials

_____
FNP's Initials
Drs. Jones, Carruthers, Hicks
Linda Holmes, Caiti Riden Livvy
Weaver, Kyle Hershberger

1.The symptom(s) that have prompted me to seek care today include:_____

_____

_____

2.And are the result of (darken circle):

○An accident or injury: ○Work ○Auto ○A worsening problem

○An interest in: ○Wellness ○Other

3.Onset (When did you first notice your current symptoms?) _____

4.Intensity (How extreme are your current symptoms?) 0 ○○○○○○○○○○ 10

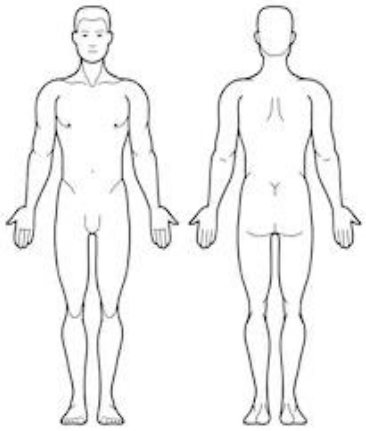
Absent Uncomfortable Agonizing

5. Duration and Timing(when did it start and how often do you feel it?) ○Constant ○Comes and goes

6. Quality of Symptoms
(What does it feel like?)

- ○Numbness
- ○Tingling
- ○Stiffness
- ○Dull
- ○Aching
- ○Cramps
- ○Nagging
- ○sharp
- ○Burning
- ○Shooting
- ○Throbbing
- ○Stabbing
- ○Other _____

7. Location(where does it hurt?)
Circle the area(s) on the illustration.
"O" for current conditions
"X" for conditions in the past



8. Radiation(does it affect other Areas of your body? To what areas does the pain radiate, shoot or travel?) _____
_____

9. Aggravating or relieving factors
(what makes it better or worse, such as time of day, movements, certain activities, etc.?)
What tends to worsen the problem? _____

_____

What tends to lessen the problem?_____

_____

10. Prior interventions(what have you done to relieve the symptoms?)

○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic
○ Physical Therapy ○ Massage

11. What else should we know about your current condition?_____
_____

12. How does your current condition interfere with your:

- Work or career: _____
- Recreational activities: _____
- Household responsibilities: _____
-Personal Relationships: _____

13. Review of symptoms Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire boy. Please darken the circle beside any condition that you have had or have.

A. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck Pain	○	○	Back problems	○	○	Hip Disorders
○	○	Knee Injuries	○	○	Foot/Ankle Pain	○	○	Shoulder Pain	○	○	Elbow/wrist pain	○	○	TMJ Issues	○	○	Poor Posture

B. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

C. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	High blood Pressure	○	○	Low Blood Pressure	○	○	High Cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive Bruising

D. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

_____
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Kyle Hershberger

E. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

F. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of taste	○	○	Loss of smell

G. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Skin Cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair Loss	○	○	Rash

H. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Thyroid issues	○	○	Immune Disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy

I. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate Issues	○	○	Erectile Disfunction	○	○	PMS Symptoms

J. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
○	○	Fainting	○	○	Low Libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight Gain/loss (circle 1)	○	○	Weakness

Past Personal, family and social history

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

Personal

14. Illness

Check the illnesses you have HAD in the past or HAVE now

HAD/ HAVE		HAD/ HAVE	
○	○ Aids	○	○ Malaria
○	○ Alcoholism	○	○ Measles
○	○ Allergies	○	○ Multiple Sclerosis
○	○ Arteriosclerosis	○	○ Mumps
○	○ Cancer	○	○ Polio
○	○ Chicken Pox	○	○ Rheumatic Fever
○	○ Diabetes	○	○ Scarlet Fever
○	○ Epilepsy	○	○ Stroke
○	○ Glaucoma	○	○ Tuberculosis
○	○ Goiter	○	○ Typhoid fever
○	○ Gout	○	○ Ulcer
○	○ Heart disease	○	○ Other _____
○	○ Hepatitis	_____	
○	○ HIV positive	_____	

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic Surgery
- ○ Elective Surgery: _____
- ○ Eye Surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine: _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other:_____

16. Treatment

Check the ones you've Received in the past or currently

Past/ Currently	
○	○ Acupuncture
○	○ Antibiotics
○	○ Birth Control pills
○	○ Blood Transfusions
○	○ Chemotherapy
○	○ Chiropractic Care
○	○ Dialysis
○	○ Herbs
○	○ Homeopathy
○	○ Hormone replacement
○	○ Inhaler
○	○ Massage therapy
○	○ Physical Therapy
○	○ Nutritional supplements
_____	
_____	

17. Injuries

Have you ever…

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

_____
Patient Name

_____
Pt#

_____
Doctor's Initials

_____
FNP's Initials

Drs. Jones, Carruthers, Hicks
Linda Holmes, Caiti Riden
Livvy Weaver
Kyle Hershberger

Family

18. Family History- Some health issues are hereditary. Tell us about the health of your immediate family members.

Relative	Age(If living)	State of health		Illness	Age of death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	O	O	_____	_____	O	O
Father	_____	O	O	_____	_____	O	O
Sister1	_____	O	O	_____	_____	O	O
Sister2	_____	O	O	_____	_____	O	O
Brother1	_____	O	O	_____	_____	O	O
Brother2	_____	O	O	_____	_____	O	O

19. Are there any other hereditary health issues that you know about? _____

Social

20. Social History- Tell us about your health habits and stress levels.

Alcohol use ○Daily ○Weekly How much? _____
Coffee use ○Daily ○Weekly How much? _____
Tobacco use ○Daily ○Weekly How much? _____
Exercising ○Daily ○Weekly How much? _____
Pain relievers ○Daily ○Weekly How much? _____
Soft drinks ○Daily ○Weekly How much? _____
Water intake ○Daily ○Weekly How much? _____
Hobbies: _____

Prayer or mediation? ○Yes ○No
Job pressure/ stress? ○Yes ○No
Financial peace? ○Yes ○No
Vaccinated? ○Yes ○No
Mercury fillings? ○Yes ○No
Recreational drugs? ○Yes ○No

21. Activities of daily living- How does this condition currently interfere with your life and ability to function?

	No Effect	Mild	Moderate	Severe		No Effect	Mild	Moderate	Severe
Sitting-	○	○	○	○	Grocery Shopping-	○	○	○	○
Rising out of chair-	○	○	○	○	Household chores-	○	○	○	○
Standing-	○	○	○	○	Lifting objects-	○	○	○	○
Walking-	○	○	○	○	Reaching overhead-	○	○	○	○
Lying down-	○	○	○	○	Showering/ bathing-	○	○	○	○
Bending over-	○	○	○	○	Dressing-	○	○	○	○
Climbing stairs-	○	○	○	○	Love life-	○	○	○	○
Using computer-	○	○	○	○	Getting to sleep-	○	○	○	○
Getting in/out of car-	○	○	○	○	Staying asleep-	○	○	○	○
Driving a car-	○	○	○	○	Concentrating-	○	○	○	○
Looking over shoulder-	○	○	○	○	Exercise-	○	○	○	○
Caring for family-	○	○	○	○	Yard work-	○	○	○	○

22. Acknowledgements-

Initials

_____ I instruct the providers to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractor/ medical care offered in this procedure is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realize that an x-ray exam may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.

_____ I grant permission to be called to confirm/ reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____

Signature **Date**

_____
Patient Name

_____
Pt #

_____
Doctor's Initials

_____
FNP's Initials

Drs. Jones, Carruthers, Hicks
Linda Holmes, Caiti Riden
Livvy Weaver
Kyle Hershberger

Oswestry Neck Pain Scale

Patient:_____DOB:_____ PT#: _____ Date: _____

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Instructions: Please circle **ONE NUMBER** in each section which most closely describes your problem.

Section 1- Pain Intensity
0 - I have no pain at the moment
1 - The pain is mild at the moment
2 - The pain come and goes and is moderate
3 - The pain is moderate and does not vary much
4 - The pain come and goes and is severe
5 - The pain is severe and does not vary much

Section 2- Personal Care (washing, dressing, etc.)
0 - I would not have to change my way of washing or dressing in order to avoid pain
1 - I do not normally change my way of washing or dressing even though it causes some pain
2 - Washing and dressing increase the pain but I manage not to change my way of doing it
3 - Washing and dressing increase the pain and I find it necessary to change my way of doing it
4 - Because of the pain I am unable to do some washing and dressing without help
5 - Because of the pain I am unable to do any washing and dressing without help

Section 3- Lifting
0 - I can lift heavy weights without extra pain
1 - I can lift heavy weights but it gives extra pain
2 - Pain Prevents me lifting heavy weights off the floor
3 - Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
4 - Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
5 - I can only lift very light weights at most

Section 4- Reading
0 - I can read as much as I want to with no pain in my neck
1 - I can read as much as I want with slight pain in my neck
2 - I can read as much as I want with moderate pain in my neck
3 - I cannot rewas as much as I want to because of moderate pain in my neck
4 - I cannot read as much as I want to because of severe pain in my neck
5 - I cannot read at all

Section 5- Headache
0 - I have no headaches at all
1 - I have slight headaches that come infrequently
2 - I have moderate headaches that come infrequently
3 - I have moderate headaches that come frequently
4 - I have severe headaches that come frequently
5 - I have headaches almost all of the time

Section 6- Concentration
0 - I can concentrate fully when I want to with no difficulty
1 - I can concentrate fully when I want to with slight difficulty
2 - I have a fair degree of difficult in concentrating when I want to
3 - I have a lot of difficulty in concentrating when I want to
4 - I have a great deal of difficulty in concentrating when I want to
5 - I cannot concentrate at all

Section 7- Work
0 - I can do as much work as I want to
1 - I can do 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 do any work at all
5 - I cannot drive my car at all

Section 8- Driving
0 - I can drive my car without any neck pain
1 - I can drive my car as long as I want with slight pain in my neck
2 - I can drive my car as long as I want with moderate pain in my neck
3 - I cannot drive my car as long as I want because of moderate pain in my neck
4 - I can hardly drive at all because of severe pain in my neck
5 - I can not drive my car at all

Section 9- 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)

Section 10- Recreation
0 - I am able to engage in all my recreational activities, with no neck pain at all
1 - I am able to engage in all of my recreational activities with some pain in my neck
2 - I am able to engage in most, but not all of my usual recreational activities because of pain in my neck
3 - I am able to engage in only a few of my usual recreational activities because of pain in my neck
4 - I can hardly so an activity because of pain in my neck
5 - I cannot do any recreational activities at all

Office Use Only:

Score %: _____

Total:_____

Doctor's Initials:_____

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Kyle Hershberger, PT, DPT

Oswestry Low Back Pain Scale

Patient:_____DOB:_____ PT#: _____ Date: _____

Please rate the severity of your pain by circling a number below:

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

Instructions: Please circle **ONE NUMBER** in each section which most closely describes your problem.

Section 1- Pain Intensity
0 - The pain comes and goes and is very mild
1 - The pain is mild and does not vary much
2 - The pain come and goes and is moderate
3 - The pain is moderate and does not vary much
4 - The pain come and goes and is severe
5 - The pain is severe and does not vary much

Section 2- Personal Care (washing, dressing, etc.)
0 - I would not have to change my way of washing or dressing in order to avoid pain
1 - I do not normally change my way of washing or dressing even though it causes some pain
2 - Washing and dressing increase the pain but I manage not to change my way of doing it
3 - Washing and dressing increase the pain and I find it necessary to change my way of doing it
4 - Because of the pain I am unable to do some washing and dressing without help
5 - Because of the pain I am unable to do any washing and dressing without help

Section 3- Lifting
0 - I can lift heavy weights without extra pain
1 - I can lift heavy weights but it gives extra pain
2 - Pain Prevents me lifting heavy weights off the floor
3 - Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table
4 - Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
5 - I can only lift very light weights at most

Section 4- Walking
0 - I have no pain when walking
1 - I have some pain when walking but it does not increase with distance
2 - I cannot walk more than 1 mile without pain
3 - I cannot walk more than ½ mile without pain
4 - I cannot walk more than ¼ mile without pain
5 - I cannot walk at all without pain

Section 5- Sitting
0 - I can sit in any chair as long as I like
1 - I can sit only in my favorite chair as long as I like
2 - Pain prevents me from sitting more than 1 hour
3 - Pain prevents me from sitting more than ½ hour
4 - Pain prevents me from sitting more than 10 minutes
5 - I avoid sitting because it increases pain immediately

Section 6- Standing
0 - I can stand as long as I want without pain
1 - I have some pain standing but it does not increase
2 - I cannot stand for longer than 1 hour without pain
3 - I cannot stand for longer than ½ hour without pain
4 - I cannot stand for longer than 10 minutes without pain
5 - I avoid standing because it increases pain

Section 7- Sleeping
0 - I get no pain in bed
1 - I get pain in bed but it does not prevent me from sleeping
2 - Because of pain my normal nights sleep is reduces by less than ¼
3 - Because of pain my normal nights sleep is reduced by less than half
4 - Because of pain my normal nights sleep is reduced by less than ¾
5 - Pain prevents me from sleeping at all

Section 8- Social Life
0 - My social life is normal and gives me no pain
1 - My social life is normal but it increases my pain
2 - Pain has no significant effect on my social life apart from limiting my more energetic interests
3 - Pain has restricted my social life and I do not go out often
4 - Pain has restricted my social life to my home
5 - I hardly have any social life due to pain

Section 9- Traveling
0 - I get no pain when traveling
1 - I get some pain when traveling but none of my usual forms of travel make it any worse
2 - I get extra pain while traveling but it does not compel me to seek other forms of travel
3 - I get extra pain while traveling which has me seek other forms of travel
4 - Pain restricts me to short necessary journeys under ½ hour
5 - Pain restricts all forms of travel

Section 10- Changing Degree of Pain
0 - My pain is rapidly getting better
1 - My pain fluctuates but is definitely getting better
2 - My pain seems to be getting better but improvement is slow
3 - My pain is neither getting better or worse
4 - My pain is gradually worsening
5 - My pain is rapidly worsening

Office Use only:

Score %: _____

Total:_____

Doctor's Initials:_____

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Kyle Hershberger, PT, DPT

Consent For Chiropractic Exam and Treatment

Jones Chiropractic Clinic

Dr. Jones Dr. Hicks Dr. Carruthers

Patient:_____DOB:_____ PT#: _____ Date: _____

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system and the nervous system, and the effects of these disorders on general health. The primary treatment provided byDoctors of Chiropractic is spinal manipulative therapy, also referred to as an adjustment. A Doctor of Chiropractic uses his/her hands and/or a mechanical instrument on the patient's body in such a way as to move the patient's joints, This may cause an audible “pop” or “click”, Such as when a person “cracks” his knuckles.The patient may feel a sense of movement as well.

Other procedures commonly used by Doctors of Chiropractic include the following:

- Physical examination- ultrasound therapy- laser therapy- palpation- postural analysis- hot/cold therapy- traction/ decompression- rehabilitation- vital signs- diagnostic studies- electrical muscle stimulations- bracing and support applications- manual therapy- acupuncture/ dry needling

The material risks associated with chiropractic treatment

Chiropractic treatment utilizes very safe, non-invasive procedures performed in chiropractic offices to reduce pain, restore range of motion, and promote overall body wellness, among other carious benefits. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. Possible complications include but are not limited to the following: muscle strain, dizziness, nausea, slushing, fractures, disc injuries, dislocations, cervical myelopathy, burns, costovertebral strains and separations. It is not uncommon for the patients to experience temporary soreness after the first few treatments. In rare cases, manipulation of the neck has been associated with injuries to the arteries in the neck, leading to or contributing to serious complications, including stroke.

The probability of those risks occurring

Fractures are rare occurrences and generally result from underlying weakness of the bone for which the Doctor of Chiropractic checks during the taking of the patient's history, and during the examination and x-ray. The incidences of stroke are exceedingly rare and are estimated to accrue between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options may include the following

There are risks and benefits associated with all the above treatment options, which the patient may wish to discuss with his/her medical doctor.

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatories, muscle relaxants, and pain killer
- Hospitalization/ surgery

Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Failure to seek care could result in serious medical conditions going unrecognized. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

Signature on back →

(cont)

I understand and accept that:

1. I have the right to withdraw from or discontinue treatment at any time and the Drs. Jones, Carruthers and Hicks will advise me of any material risks in this regard.
2. Neither the practice of chiropractic nor the practice of medicine is an exact science, and my care may involve the making of judgements based upon the facts known to the doctor during the course of my care.
3. It is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, and an undesirable result does not necessarily indicate an error in judgement or treatment,
4. Drs. Jones, carruthers, or Hicks does not guarantee any results with respect to any course of care or treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. ONCE READ AND UNDERSTOOD, PLEASE CHECK THE APPROPRIATE BLOCK IN THE PARAGRAPH BELOW AND SIGN.

Patient:

I [ ] have read, or [ ] have had read to me, the above exclamation of chiropractic adjustment and related treatment. I hereby authorize Drs. Jones, Carruthers or Hicks and his/hers assistants, associates and other appropriate persons to render care, to perform an examination and to provide an appropriate evaluation and treatment plan to address the complaints, problems, and medical history I have provided. I have discussed any questions, comments, or concerns with Drs, Jones, Carruthers, or Hicks and have had my inquiries answered to my satisfaction.

By signing below, I state that I have weighed the risks and/ or benefits in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to the treatment.

_____

Patient Name

_____

Patient Signature

_____

Date

_____

Parent/ Guardian Signature

Jones Chiropractic Clinic
801 East watauga Ave
Johnson City, TN 37601
Dr. Jones Dr. Hicks Dr. Carruthers

Pt#: _____

Consent For Treatment

Total Health and Wellness

Tom Rogers, M.D. / Linda Holmes, FNP-BC / Caiti Riden, FNP-C / Livvy Weaver, FNP-C / Kyle Hershberger, PT, DPT

General consent for treatment and test: I consent to treatment by the Total Health and Wellness physician, nurse practitioner, nurses, technicians, staff for my illness and/or health evaluations, Including but not limited to x-rays, blood tests, laboratory procedures, injections, medications, exercises, modalities, muscles work, stretches, and minor procedures. I acknowledge and agree physicians to report certain communicable diseases to the health department.
____ **Initials**

Independently practicing doctors: I understand and agree that most of the radiologist, pathologist, anesthesiologists, and some allied health professionals are engaged in the practice of their professions on behalf of themselves or other corporations and do not practice as employees of Total Health and Wellness. I hereby authorize payment directly to the physicians. I also authorize the release of my medical information necessary to process these insurance claims.
____ **Initials**

Release from liability for leaving against medical advice: I agree that if I leave a physician's office against the advice of my physician or the Total Health and Wellness staff, then Total Health and Wellness, its personnel, and my physician are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice.
____ **Initials**

Controlled substance policy: It is not the policy of Total health and Wellness to write controlled substances to our patients. Patients who require chronic pain and mental health medications will be directed to a specialist for evaluation and treatment. The is NO controlled substance kept on hand at Total Health and Wellness.
____**Initials**

Authorization to release medical information: I authorize Total Health and Wellness and all physician's involved in my care to disclose and release my medical information (which may include alcohol and drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to each other and to any person or organization which is or may be liable or responsible for payment of my bill, including Medicare intermediaries and fiscal agents.
____**Initials**

I have read and fully understand this document, and I agree to its terms.

_____	_____	_____
Print Patient Name	Patient Signature	Date of Birth

_____	_____
Staff/ Witness	Date

Total Health and Wellness
801 East Watauga Ave.
Johnson City, TN 37601
Linda Holmes, FNP-BC Caiti Rden FNP-C Livvy Weaver, FNP-C Kyle Hershberger, PT, DPT

Pt#: _____

Financial Agreement

1. All Patients are on a cash basis until their insurance coverage may be verified.
2. Waiting for the insurance to pay is a courtesy and it can be withdrawn under any circumstance.
3. As a patient, it is your responsibility to take care of the co- pay and any non- coverage service on a weekly basis. Other arrangements can be made.
4. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that your insurance will or should pay the fees charged. Insurance policies are an arrangement between the insured and the insurance company.
5. This office will resubmit a claim one time. This office will NOT enter into a dispute with your insurance company. If coverage problems arise, you will be expected to contact your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as non- covered services and you will be expected to pay such charges in a timely manner.
6. Any refunds that are due to you will be issued once your insurance company makes complete payments.
7. If you receive any correspondences or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken.
8. If your account is sent to a collection agency, you agree to pay the collection fee of 33.3% in addition to your outstanding balance owed to Jones Chiropractic Clinic.
9. There is a $25.00 return check fee.

I have read and I understand the above financial policy. I agree and will abide by these terms.

_____ Date:_____

Patient Signature (or responsible party)

_____ Date:_____

Witness Signature

Jones Chiropractic Clinic
801 E. Watauga Ave
Johnson City, TN 37601
Dr. Jones Dr. Hicks Dr. Carruthers

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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient:_____DOB:_____ PT#: _____ Date: _____

I hereby acknowledge that I have received that I have received and have been given an opportunity to read a copy of Jones Chiropractic Clinic's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the office manager at 423-929-3700.

_____ _____

Signature of patient **Date**

_____ _____

Parent or Guardian/ Personal Representative **Date**

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual.

_____ _____

Signature of staff member **Date**

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Patient Health Questionnaire

Patient:_____ DOB:_____ PT#: _____ Date: _____

Over the last 2 Weeks, how often have you been bothered by any of the following problems?

(Please circle the number that applies)

	Not at all	Several Days	More than half the days	Nearly every day
1.Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have notices. Or the opposite, being fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

Add Columns:				

Total:	

10. If you checked off any problems, How difficult	Not difficult at all _____
Have these problems made it for you to do	Somewhat difficult _____
Your work , take care of things at home, of get	Very Difficult _____
Along with others?	Extremely difficult _____

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PATIENT NAME_____ DOB_____

PATIENT #_____ DATE_____

TOTAL HEALTH AND WELLNESS
801 E Watauga Ave Ste. #2
Johnson City, TN 37601
(423) 929-3700

Patient-specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at the same level as before injury or problem

1. LIST 5 ACTIVITIES YOU HAVE DIFFICULTY WITH DUE TO YOUR CURRENT CONDITION

2. UNDER SCORE, 0-10 HOW WELL ARE YOU CURRENTLY ABLE TO COMPLETE EACH ACTIVITY

*****(0-unable to perform, 10-able to complete without difficulty)*****

(Date and Score)

	DATE					
Activity	**SCORE**					
1.						
2.						
3.						
4.						
5.						
Additional						
Additional						

*****BELOW IS FOR OFFICE USE ONLY*****

Total score = sum of the activity scores/number of activities
Minimum detectable change (90%CI) for average score = 2 points
Minimum detectable change (90%CI) for single activity score = 3 points

PSFS developed by: Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263.

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