

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. Shannon Dr. Carruthers
Joneschiroclinic@gmail.com

Total Health and Wellness

801 E. Watauga Ave.
Johnson City, TN 37601

Doctor's Initials

FNP's Initials

Drs. Jones, Carruthers, Shannon
Margaret Vanderveen,
Ashley Keylon, Tyson Nickels

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

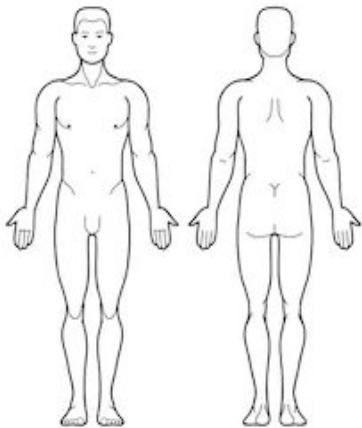
6. Quality of Symptoms

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

A. Musculoskeletal

- | | | | | | | | |
|---------------------------|-------------------------------------|---------------------------|--|---------------------------|-------------------------------------|---------------------------|---------------------------------------|
| Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> Osteoporosis | <input type="radio"/> | <input type="radio"/> Arthritis | <input type="radio"/> | <input type="radio"/> Scoliosis | <input type="radio"/> | <input type="radio"/> Neck Pain |
| <input type="radio"/> | <input type="radio"/> Back problems | <input type="radio"/> | <input type="radio"/> Hip Disorders | <input type="radio"/> | <input type="radio"/> Knee Injuries | <input type="radio"/> | <input type="radio"/> Foot/Ankle Pain |
| <input type="radio"/> | <input type="radio"/> Shoulder Pain | <input type="radio"/> | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> | <input type="radio"/> TMJ Issues | <input type="radio"/> | <input type="radio"/> Poor Posture |

B. Neurological

- | | | | | | | | |
|---------------------------|--|---------------------------|----------------------------------|---------------------------|--------------------------------|---------------------------|---------------------------------|
| Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> Anxiety | <input type="radio"/> | <input type="radio"/> Depression | <input type="radio"/> | <input type="radio"/> Headache | <input type="radio"/> | <input type="radio"/> Dizziness |
| <input type="radio"/> | <input type="radio"/> Pins and needles | <input type="radio"/> | <input type="radio"/> Numbness | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

C. Cardiovascular

- | | | | | | | | |
|---------------------------|---|---------------------------|--|---------------------------|--|---------------------------|--|
| Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> High blood Pressure | <input type="radio"/> | <input type="radio"/> Low Blood Pressure | <input type="radio"/> | <input type="radio"/> High Cholesterol | <input type="radio"/> | <input type="radio"/> Poor circulation |
| <input type="radio"/> | <input type="radio"/> Angina | <input type="radio"/> | <input type="radio"/> Excessive Bruising | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

D. Respiratory

- | | | | | | | | |
|---------------------------|------------------------------|---------------------------|-----------------------------|---------------------------|---------------------------------|---------------------------|---|
| Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> | Had <input type="radio"/> | Have <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> Asthma | <input type="radio"/> | <input type="radio"/> Apnea | <input type="radio"/> | <input type="radio"/> Emphysema | <input type="radio"/> | <input type="radio"/> Hay fever |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Shortness of breath |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> Pneumonia |

Patient Name

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Nickels

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 Dysfunction 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.

13. Illness

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

- | HAD/ HAVE | HAD/ HAVE |
|--|--|
| <input type="radio"/> <input type="radio"/> Aids/HIV | <input type="radio"/> <input type="radio"/> Malaria |
| <input type="radio"/> <input type="radio"/> Alcoholism | <input type="radio"/> <input type="radio"/> Measles |
| <input type="radio"/> <input type="radio"/> Allergies | <input type="radio"/> <input type="radio"/> Multiple Sclerosis |
| <input type="radio"/> <input type="radio"/> Arteriosclerosis | <input type="radio"/> <input type="radio"/> Mumps |
| <input type="radio"/> <input type="radio"/> Cancer | <input type="radio"/> <input type="radio"/> Polio |
| <input type="radio"/> <input type="radio"/> Chicken Pox | <input type="radio"/> <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> <input type="radio"/> Diabetes | <input type="radio"/> <input type="radio"/> Scarlet Fever |
| <input type="radio"/> <input type="radio"/> Epilepsy | <input type="radio"/> <input type="radio"/> Stroke |
| <input type="radio"/> <input type="radio"/> Glaucoma | <input type="radio"/> <input type="radio"/> Tuberculosis |
| <input type="radio"/> <input type="radio"/> Goiter | <input type="radio"/> <input type="radio"/> Typhoid fever |
| <input type="radio"/> <input type="radio"/> Gout | <input type="radio"/> <input type="radio"/> Ulcer |
| <input type="radio"/> <input type="radio"/> Heart disease | <input type="radio"/> <input type="radio"/> Other _____ |
| <input type="radio"/> <input type="radio"/> Hepatitis | _____ |

14. 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: _____

15. 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

Your current Medications: _____

Any known Allergies: _____

16. Injuries

Have you ever...

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

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PAGE 3/4

Personal

Family

17. 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	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

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

Social

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

- Alcohol use Daily Weekly How much? _____ Prayer or mediation? Yes No
- Coffee use Daily Weekly How much? _____ Job pressure/ stress? Yes No
- Tobacco use Daily Weekly How much? _____ Financial peace? Yes No
- Exercising Daily Weekly How much? _____ Vaccinated? Yes No
- Pain relievers Daily Weekly How much? _____ Mercury fillings? Yes No
- Soft drinks Daily Weekly How much? _____ Recreational drugs? Yes No
- Water intake Daily Weekly How much? _____
- Hobbies: _____

20. 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-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery Shopping-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering/ bathing-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using computer-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercise-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work-	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. 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.

Patient Name

Pt #

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Nickels

Signature

Date

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 read 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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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

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- 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

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Tyson Nickels, MSN-FNP

Pt#: _____

Consent For Treatment

Total Health and Wellness

Ankur Bhargava, MD/ Margaret Vanderveen, FNP/ Ashley keylon, FNP-BC/ Tyson Nickels, MSN-FNP

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 with 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. There 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

Date

Total Health and Wellness
801 East Watauga Ave.
Johnson City, TN 37601

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

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

I hereby acknowledge 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

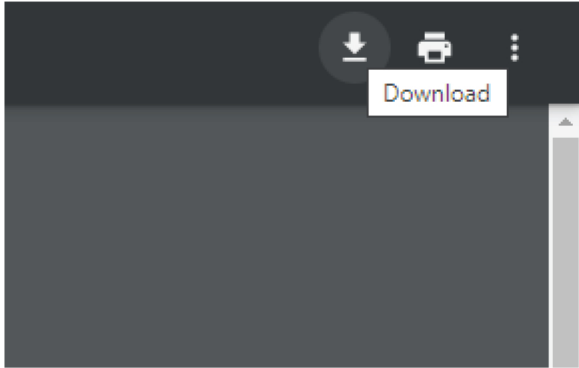
Jones Chiropractic Clinic
801 E. Watauga Ave
Johnson City, TN 37601
Dr. Jones Dr. Shannon Dr. Carruthers

Total Health and Wellness
801 E. Watauga Ave.
Johnson City, TN 37601
Margaret Vanderveen, FNP Ashley Keylon, FNP-BC

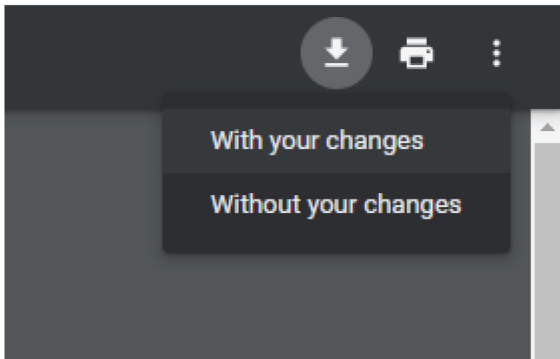
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