Name: ____ Date: _________________

New Injury / Patient Update:

DOB: _________________________ SSN:______________________ Marital Status: M S D W

Phone: (H) ______________________ (W) ______________________ (C) ______________________

Address: ____

City: ______________________________ State: _________ Zip: ________________

Occupation: ____________________________ Employer: ____________________________________

Emergency Contact Name:_________________________Emergency Contact Number:_________________

☐ I authorize Koerner Chiropractic and Physical Therapy to leave or give information to my emergency contact.

Email Address: _______________________________________

☐ I authorize Koerner Chiropractic and Physical Therapy to send me emails for reminders and informational newsletters.

Purpose of this visit: ____

How/When Symptoms Appeared:

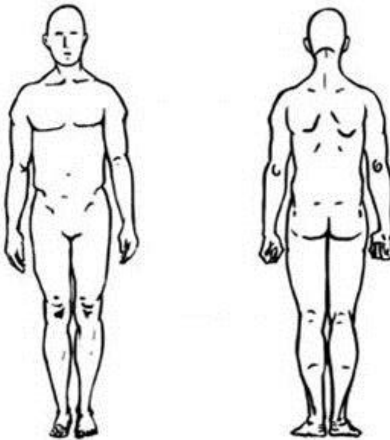
____

____

____

____

Mark areas where you are experiencing pain with an "X."



Serious Illnesses since last visit: ____

Insurance Coverage: ____

Secondary Insurance Coverage (if applicable): ____

Any new information the doctor should know about your condition or your health in general?

____

____

Koerner Chiropractic and Physical Therapy
2707 Vine St. Ste #1, Hays, KS 67601
Phone (785) 628-2105 Fax (785) 628-2165

Name: ____ Date: ___________________

Review of Systems

Pulmonary (lung-related) issues?

□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other ___________ □ None of the above

Cardiovascular (heart-related) issues or procedures?

□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems

□ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other __________ □ None of the above

Neurological (nerve-related) issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell

□ Strokes/TIAs □ Other ______________ □ None of the above

Endocrine (glandular/hormonal) related issues or procedures?

□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes

□ Other _______________ □ None of the above

Renal (kidney-related) issues or procedures?

□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections

□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____________________ □ None of the above

Gastroenterological (stomach-related) issues?

□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation

□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools

□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other ________ □ None of the above

Hematological (blood-related) issues?

□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive

□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia

□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use

□ Other ______________ □ None of the above

Dermatological (skin-related) issues?

□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _________ □ None of the above

Musculoskeletal (bone/muscle-related) issues?

□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery

□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____________________ □ None of the above

Psychological issues?

□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia

□ Psychiatric hospitalizations □ Other ___________ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here?

____

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient or Guardian Signature _____________________________ Date_______________________

FOR OFFICE USE ONLY:
Practitioner: ________________
Reviewed Date: ______________

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Name: ____ Date: __________________

PATIENT HISTORY FORM

Symptom 1 (Primary Complaint): ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
- Did the symptom begin suddenly or gradually? (circle one)
- How did the symptom begin? _______________________________________
- What makes the symptom worse? (circle all that apply):
  Lying on back, lying on side, turning in bed, laying on stomach, exercise, moving neck, getting in/out of car, gripping, dressing self, kneeling, stretching, getting in/out of bed, housework, sleeping, pulling, reaching, computer use, moving back, walking, squatting, bending forward, bending backward, stress, sitting, standing, sneezing, coughing, reading, sit to stand, other (please describe): __________________________
- What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
- If yes, where does the symptom radiate? _______________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

Symptom 2 (Secondary Complaint): ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? ____
- Did the symptom begin suddenly or gradually? (circle one)
- How did the symptom begin? _______________________________________
- What makes the symptom worse? (circle all that apply):
  Lying on back, lying on side, turning in bed, laying on stomach, exercise, moving neck, getting in/out of car, gripping, dressing self, kneeling, stretching, getting in/out of bed, housework, sleeping, pulling, reaching, computer use, moving back, walking, squatting, bending forward, bending backward, stress, sitting, standing, sneezing, coughing, reading, sit to stand, other (please describe): __________________________
- What makes the symptom better? (circle all that apply): Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe): ____
- Describe the quality of the symptom (circle all that apply):
  Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging
  Other (please describe): ____
- Does the symptom radiate to another part of your body (circle one): yes no
- If yes, where does the symptom radiate? _______________________________
- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

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Name: ____ Date: _________________

Informed consent for Chiropractic Spinal Manipulation, Diagnostic X-Rays and Treatment, Authorization and Release

I hereby request and consent to the performance of chiropractic manipulation and other chiropractic procedures, including various modes of therapy modalities (including but not limited to ultrasound, muscle stimulation, interferential, ice, heat, traction, spinal decompression, Graston soft tissue, Kinesio/Rock Tape) and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by or under the orders of the licensed doctors of chiropractic of the Koerner Chiropractic and Physical Therapy or any doctor, who now or in the future, works as a relief doctor.
Initials______

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic manipulation and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand an 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, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications and realize that alternative to care might include self-administered over the counter analgesics and rest, medical treatment; prescription drugs, such as anti-inflammatory, muscle relaxants and pain-killers, surgery or doing nothing. I understand the risks and dangers attendant to remaining untreated; over time this may complicate treatment making it more difficult and less effective the linger treatment is postponed. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.
Initials______

I authorize payment of insurance benefits directly to the Koerner Chiropractic and Physical Therapy. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize the Koerner Chiropractic and Physical Therapy to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand and agree 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.
Initials______

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Name: ____ Date: __________________

I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.
Initials______

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intent this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

Patient Signature:____Date:____________________

Printed Name:____

For Females Only

To the best of your knowledge, are you pregnant (or do you think you could be)?

Yes_________ No__________ Possibly____________

Patient Signature:____Date:____________________

Consent to Treatment of a Minor Child

I hereby authorize the doctors of Koerner Chiropractic and Physical Therapy, and/or whomever they designate as assistants, to administer treatment as deemed necessary to__________________________________.

Signature of Parent or Legal Guardian:____________________________________Date:______________

Relationship:____

Witness Signature:____Date:______________

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Name: ____ Date: _________________

Patient Acknowledgement of 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.

Dated this _______ day of _________________, 20______

By___________________________________
(Patient Signature)

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

By___________________________________
Signature of Parent/Guardian (Circle One)

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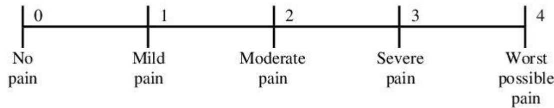
Name: ____ Date: __________________

Functional Rating Index

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

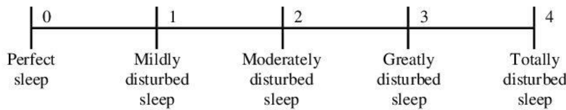
In order to properly assess your condition, we must understand how much your **neck and/or back problems** has affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now**.

1. Pain Intensity



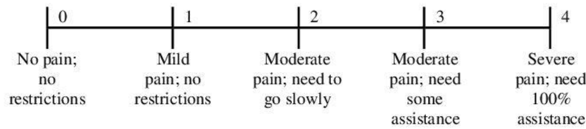
0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping



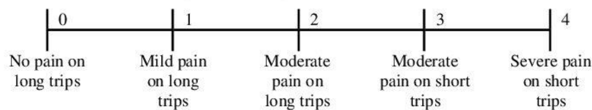
0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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



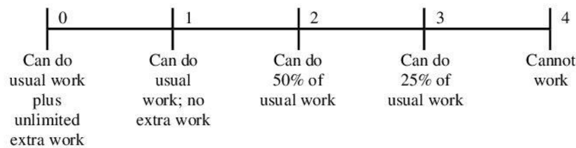
0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travelling (driving, etc.)



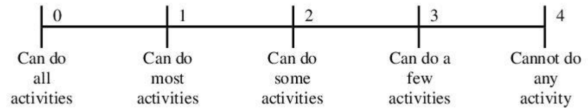
0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work



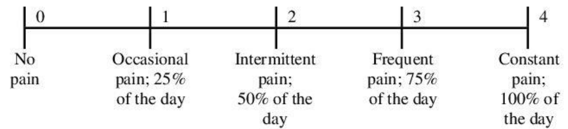
0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation



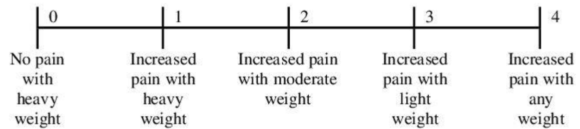
0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activity

7. Frequency of Pain



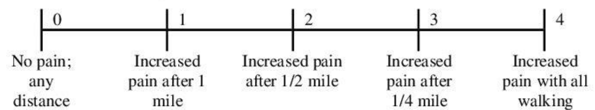
0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting



0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking



0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

_________________________________ **Patient's Signature**

____________________ **Date**

For Office Use Only:

Practitioner ID#: ______________________________

Total Score _______________ **/ 40**

Clinical Diagnosis Codes:

Patient ID#:______________________________

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0%-20% Minimal 21%-40% Moderate 41%-60% Severe 61%-80% Crippled 81%-100% Bed Bound

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