Name: _____ Date: _____

Address_____City_____ State_____ Zip Code _____

Phone: (H) _____ (W) _____ (C) _____

Email Address _____

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

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Social Security #_____

Occupation_____Employer_____

Emergency Contact Name_____Emergency Contact's Number_____

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

Referred by: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor/Office: _____

1. Reasons for seeking chiropractic care:

Primary reason:

_____

_____

Secondary reason:

_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____

_____

_____

3. Past Health History:

A. Please indicate if you have a history of any of the following:

☐ Anticoagulant use ☐ Heart problems/high blood pressure/chest pain ☐ Bleeding problems

☐ Lung problems/shortness of breath ☐ Cancer ☐ Diabetes ☐ Psychiatric disorders

☐ Bipolar disorder ☐ Major depression ☐ Schizophrenia ☐ Stroke/TIA's ☐ Other _____

☐ None of the above

B. Previous Injury or Trauma:

_____

_____

_____

Have you ever broken any bones? Which?

_____

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Name: _____ Date: _____

C. Allergies:

_____

D. Medications:

Medication Reason for taking

_____

_____

_____

_____

E. Surgeries:

Date Type of Surgery

_____

_____

_____

_____

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery Outcome

_____

_____

_____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Headaches □ Cardiac disease □ Neurological diseases

□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease □ Diabetes

□ Other _____ □ None of the above

Cause of parents or siblings death Age at death

_____

_____

_____

5. Social and Occupational History:

A. Job description: _____

B. Work schedule: _____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

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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

N**eurological (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

M**usculoskeletal (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: _____

NEW 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: _____

Symptom 3 (Additional 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 4 (Additional 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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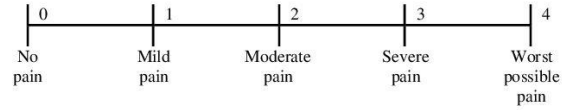
Name: _____ Date: _____

Functional Rating Index

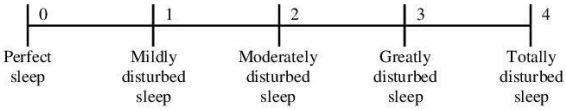
For use with **Neck and/or Back Problems** only.

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**.

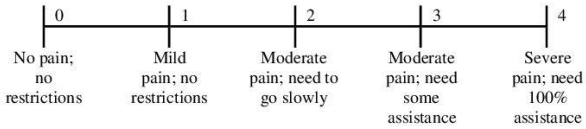
1. Pain Intensity



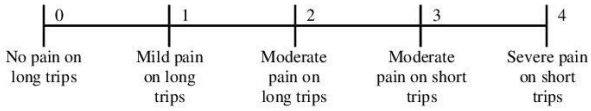
2. Sleeping



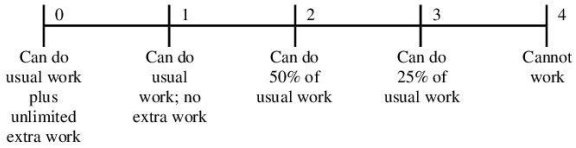
3. Personal Care (washing, dressing, etc.)



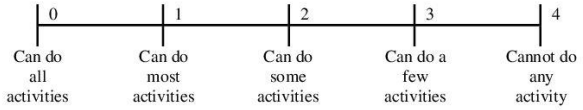
4. Travelling (driving, etc.)



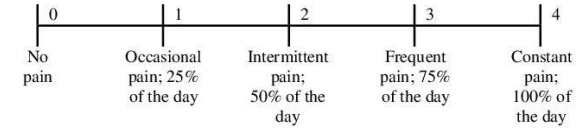
5. Work



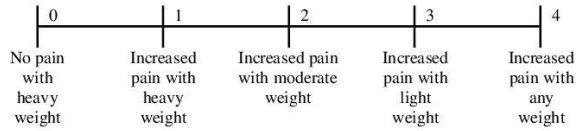
6. Recreation



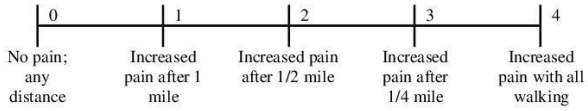
7. Frequency of Pain



8. Lifting



9. Walking



10. Standing

_____ _____

Patient's Signature **Date**

For Office Use Only:

Practitioner ID#: _____

Total Score _____ **/ 40**

Clinical Diagnosis Codes:

Patient ID#:_____

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

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