Koerner Chiropractic & Physical Therapy

PATIENT INFORMATION

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: ____

CHIEF COMPLAINT (CC)

Primary reason:

____

____

Secondary reason:

____

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

____

____

____

PAST FAMILY SOCIAL HISTORY (PFSH)

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?

____

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

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

____
____
____

1. 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

____
____
____

2. 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):

____

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

Koerner Chiropractic & Physical Therapy

Name: ____ Date: ____________________

REVIEW OF SYSTEMS (ROS)

For new patients, established patients who may be having a new problem, or our patients who we have not seen in a while, we need to update our records as to your general health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed.

Constitutional Symptoms (Health in General) ☐ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer.
Other:____

Eyes ☐ No Problems Blurred vision, crossed eyes, eye pain, discharge
Other:____

Ears, Nose, Mouth & Throat ☐ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness.
Other:____

Cardiovascular (Heart Related) ☐ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other:____

Respiratory (Lungs & Breathing) ☐ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray.
Other:____

Gastrointestinal (Stomach & Intestines) ☐ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.
Other:____

Genitourinary (Reproductive Organs & Urinary) ☐ No Problems Hematuria, excessive/reduced urination, kidney/bladder infections. Other:____

Musculoskeletal (Muscles, Bones & Joints) ☐ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other:____

Integumentary (Skin, Hair & Breast) ☐ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other:____

Neurologic (Brain & Nerves) ☐ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other:____

Psychiatric (Mood & Thinking) ☐ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other:____

Endocrine (Glands) ☐ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other:____

Hematologic/Lymphatic (Blood/Lymph) ☐ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other:____

Allergic/Immunologic ☐ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other:____

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: ______________

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

Koerner Chiropractic
& Physical Therapy

Name: ______________________________ Date: ____________

HISTORY OF PRESENT ILLNESS (HPI)

Symptom 1 (Chief Complaint): ______________________________

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:______________
- Severity: 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
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? ______________________
- Context: How did the symptom begin? ______________________
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)______________
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving Neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: 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 Constant

Symptom 2 (Secondary Complaint): ______________________________

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:______________
- Severity: 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
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? ______________________
- Context: How did the symptom begin? ______________________
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)______________
- What makes the symptom worse? (circle all that apply):

Sleeping	Turning in bed	Dressing	Walking	Sitting	Coughing
Laying on stomach	Exercise	Pulling	Bending forward	Standing	Exercise
Laying on side	Moving Neck	Reaching	Bending backward	Laughing	Sit to stand
Laying on back	In/out of car	Stress	Computer use	Sneezing	Squatting

- Associated Signs & Symptoms: 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 Constant

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

Koerner Chiropractic & Physical Therapy

Name: ______________________________ Date: ______________

Symptom 3 (Additional Complaint): ______________________________

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:__________________
- Severity: 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
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? ______________________________
- Context: How did the symptom begin? ______________________________
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)__________________
- What makes the symptom worse? (circle all that apply):
  Sleeping Turning in bed Dressing Walking Sitting Coughing
  Laying on stomach Exercise Pulling Bending forward Standing Exercise
  Laying on side Moving Neck Reaching Bending backward Laughing Sit to stand
  Laying on back In/out of car Stress Computer use Sneezing Squatting
- Associated Signs & Symptoms: 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 Constant

Symptom 4 (Additional Complaint): ______________________________

- Quality: Describe the quality of symptoms (circle all that apply):
  Sharp Dull Achy Burning Throbbing Piercing Stabbing
  Deep Nagging Shooting Stinging Other:__________________
- Severity: 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
- Timing: What percentage of the time you are awake do you experience the above symptom at the above intensity:
  0 10 20 30 40 50 60 70 80 90 100
- Duration: When did the symptom begin? ______________________________
- Context: How did the symptom begin? ______________________________
- Did the symptom begin suddenly or gradually? (circle one)
- Modifying Factors: What makes the symptom better? (circle all that apply):
  Rest ice heat stretching exercise massage pain medication
  muscle relaxers nothing Other (please describe)__________________
- What makes the symptom worse? (circle all that apply):
  Sleeping Turning in bed Dressing Walking Sitting Coughing
  Laying on stomach Exercise Pulling Bending forward Standing Exercise
  Laying on side Moving Neck Reaching Bending backward Laughing Sit to stand
  Laying on back In/out of car Stress Computer use Sneezing Squatting
- Associated Signs & Symptoms: 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 Constant

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

Koerner Chiropractic & Physical Therapy

Name: ____ Date: _________________

INFORMED CONSENT FOR CHIROPRACTIC SPINAL MANIPULATION, DIAGNOSITC 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 Koerner Chiropractic and Physical Therapy or any doctor, who now or in the future, works as a relief doctor. **Initials:__________** **Physician's Signature:______________________**

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 and 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 longer 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:__________** **Physician's Signature:______________________**

I authorize payment of insurance benefits directly to 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. 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 intend 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:____

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

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.

By___________________________________ **on**______________
Patient Signature Today's Date

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

By___________________________________
Signature of Parent/Guardian (Circle One)

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

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_______

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