Koenig Chiropractic
New Patient Paperwork

Name: _____Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone:_____Work Phone: _____

Cell Phone: _____ Cell Phone Carrier for Appointment Reminders:_____

Email Address: _____ Occupation: _____

Employer: _____ Employer Address: _____

Date of Birth: _____ Social Security #: _____ Gender: ☐Male ☐Female

Race: ☐Caucasian ☐African American ☐Asian ☐Native American Other:_____

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

How did you hear about our practice? _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

List any **Allergies**:

☐Animals	☐Eggs	☐Seasonal Allergies
☐Aspirin	☐Latex	☐Shellfish
☐Bees	☐Molds	☐Soaps
☐Chocolate	☐Penicillin	☐Wheat
☐Dairy	☐Ragweed/Pollen	☐Iodine
☐Dust	☐Rubber	Other:_____

List any **Surgeries**:

☐Back	☐Knee	Other: _____
☐Brain	☐Neck	☐Breast
☐Elbow	☐Neurological	☐Hysterectomy:
☐Foot	☐Shoulder	☐Full
☐Hip	☐Wrist	☐Partial

List **ALL** **Past Medical History** conditions:

- ☐ Ankle Pain
- ☐ Arm Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Broken Bones
- ☐ Cancer
- ☐ Chest Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Elbow Pain
- ☐ Epilepsy
- ☐ Eye/Vision Problems
- ☐ Fainting
- ☐ Fatigue
- ☐ Foot Pain
- ☐ Genetic Spinal Condition
- ☐ Hand Pain
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ HIV
- ☐ Jaw Pain
- ☐ Joint Stiffness
- ☐ Knee Pain
- ☐ Leg Pain
- ☐ Menstrual Problems
- ☐ Mid-Back Pain
- ☐ Minor Heart Problem
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Neurological Problems
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Polio
- ☐ Prostate Problems
- ☐ Shoulder Pain
- ☐ Significant Weight Change
- ☐ Spinal Cord Injury
- ☐ Sprain/Strain
- ☐ Stroke/Heart Attack

Other: _____

List Type of **Medications** you are taking:

- ☐ Anxiety
- ☐ Muscle Relaxers
- ☐ Pain Killers
- ☐ Insulin
- ☐ Birth Control
- ☐ Cardiovascular
- ☐ Allergy
- ☐ Seizure
- ☐ Hormones

Other:_____

_____

List your **Family History**:

- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Genetic Spinal Condition
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Multiple Sclerosis
- ☐ Neurological Problems
- ☐ Parkinson's
- ☐ Polio
- ☐ Prostate Problems
- ☐ Stroke/Heart Attack

Other:_____

_____

List your **Personal History**:

Have you had any auto or other accidents ☐ No ☐ Yes

Describe: _____

Date of last physical exam: _____

Do you smoke? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes - how many per day? _____

Do you drink caffeine? ☐ No ☐ Yes - how many per day? _____

Do you exercise? ☐ No ☐ Yes If yes what forms and how often: _____

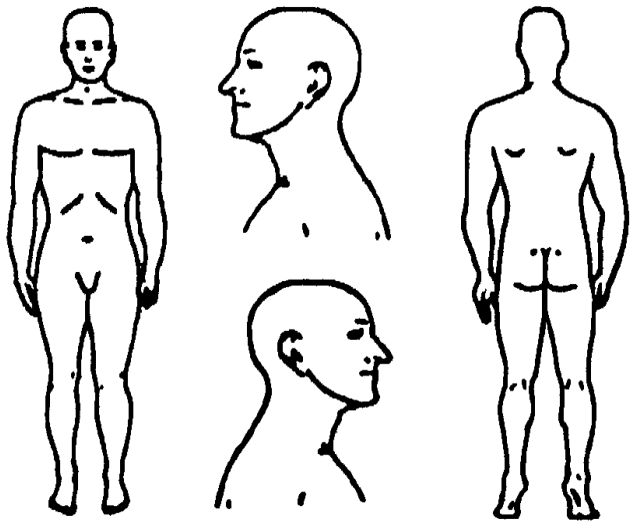
Have you ever had chiropractic care? ☐ No ☐ Yes

When? _____ Why? _____

Where? _____

Were X-rays taken? ☐ No ☐ Yes When was your last adjustment? _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

☐ Become pain free
☐ Explanation of my condition
☐ Learn how to care for my condition
☐ Reduce symptoms
☐ Resume normal activity level

What is your MAJOR complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐GETTING BETTER ☐GETTING WORSE ☐NOT CHANGING

Have you had this condition in the past? ☐YES ☐ NO

How often do you experience your symptoms?
☐Constantly (76-100% of the day) ☐Frequently (51-75% of the day)
☐Occasionally (26-50% of the day) ☐Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐Sharp ☐Dull ☐Numb ☐Burning ☐Shooting ☐Tingling

☐Radiating Pain ☐Tightness Stabbing ☐Throbbing Other: _____

Please rate your pain on a scale of 0 to 10 (0= no pain and 10= excruciating pain)
☐0☐1 ☐2 ☐3 ☐4☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10= no possible activities) ☐0☐1 ☐2 ☐3 ☐4☐5 ☐6 ☐7 ☐8☐9 ☐10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your SECOND complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐GETTING BETTER ☐GETTING WORSE ☐NOT CHANGING

Have you had this condition in the past? ☐YES ☐ NO

How often do you experience your symptoms?
☐Constantly (76-100% of the day) ☐Frequently (51-75% of the day)
☐Occasionally (26-50% of the day) ☐Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐Sharp ☐Dull ☐Numb ☐Burning ☐Shooting ☐Tingling

☐Radiating Pain ☐Tightness Stabbing ☐Throbbing Other: _____

Please rate your pain on a scale of 0 to 10 (0= no pain and 10= excruciating pain)
☐0☐1 ☐2 ☐3 ☐4☐ 5 ☐6☐7 ☐8 ☐9 ☐10

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10= no possible activities) ☐0☐1☐2 ☐3☐4 ☐5 ☐6☐7 ☐8☐9 ☐10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

What is your THIRD complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐GETTING BETTER ☐GETTING WORSE ☐NOT CHANGING

Have you had this condition in the past? ☐YES ☐NO

How often do you experience your symptoms?
☐Constantly (76-100% of the day) ☐Frequently (51-75% of the day)
☐Occasionally (26-50% of the day) ☐Intermittently (0-25% of the day)

Describe the nature of your symptoms: ☐Sharp ☐Dull ☐Numb ☐Burning ☐Shooting ☐Tingling

☐Radiating Pain ☐Tightness Stabbing ☐Throbbing Other: _____

Please rate your pain on a scale of 0 to 10 (0= no pain and 10= excruciating pain)
☐0☐1 ☐2 ☐3 ☐4☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10= no possible activities) ☐0☐1☐2 ☐3☐4☐5☐6☐7 ☐8 ☐9 ☐10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

Review of Systems

Name_____ **Date**_____

Neurological
- ☐ Migraines
- ☐ Headaches
- ☐ Slurring of speech
- ☐ Ringing in Ear

Ear/Nose/Throat
- ☐ Altered taste/smell
- ☐ Night Blindness
- ☐ Sore Throat
- ☐ Gingivitis
- ☐ Nose bleeds

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations-racing heart beat
- ☐ Swelling in hands/feet
- ☐ Anemia

Respiratory
- ☐ Recurrent Respiratory Infections
- ☐ Asthma
- ☐ Chest Congestion
- ☐ Wheezing
- ☐ Frequent Sneezing

GI
- ☐ Stomach Pains or Cramping
- ☐ Constipation
- ☐ Reflux or Heartburn
- ☐ Bloating
- ☐ Gas
- ☐ Nausea or Vomiting

Musculoskeletal
- ☐ Joint Pain
- ☐ Arthritis
- ☐ Chronic pain
- ☐ Muscle Aches

Skin
- ☐ Eczema
- ☐ Dermatitis
- ☐ Excessive Sweating
- ☐ Rashes
- ☐ Brittle Nails
- ☐ Hair Loss
- ☐ Easy Bruising
- ☐ Increased Bleeding
- ☐ Numbness/tingling

Genitourinary
- ☐ Uterine fibroids
- ☐ Ovarian cysts
- ☐ Cancer (breast, ovarian, prostate, uterine)
- ☐ Prostate problems

Emotional/Mental
- ☐ Depression
- ☐ Anxiety
- ☐ Mood Swings
- ☐ Irritability
- ☐ Memory Loss
- ☐ Confusion

Energy
- ☐ Fatigue
- ☐ Hyperactivity
- ☐ Restlessness
- ☐ Insomnia
- ☐ Decreased Libido
- ☐ Stress

Weight
- ☐ Decreased Appetite
- ☐ Weight Gain
- ☐ Inability to Lose Weight
- ☐ Food Cravings
- ☐ Binge Eating
- ☐ Water Retention

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I a may be pregnant at this time.

☐ Yes, I am definitely pregnant

☐ No, I am definitely not pregnant at this time

☐ I request that x-ray films not be taken because: _____

Date of last menstrual period: _____

_____ _____

Patient's Signature Date

Activities of Daily Living Assessment

Check all that you have difficulty performing due to your pain/condition:

☐ Baking
☐ Bathing
☐ Bending
☐ Bending Arm
☐ Bending Leg
☐ Care of others/Pets
☐ Caring for Children
☐ Carrying Objects
☐ Climbing Stairs
☐ Concentrating
☐ Cooking/Cleaning
☐ Crouching/Squatting
☐ Dancing
☐ Doctor's Visits
☐ Doing Hobbies
☐ Doing things on time
☐ Dressing
☐ Driving
☐ Eating
☐ Exercise/Sports
☐ Falling asleep
☐ Financial Management
☐ Gardening
☐ General Mobility
☐ Getting Places
☐ Hearing
☐ Holding onto objects
☐ Housework
☐ Jogging
☐ Keeping balance
☐ Knitting
☐ Leaning
☐ Lifting
☐ Light/Sound
☐ Looking
☐ Making Decisions
☐ Moving Joint(s)
☐ Mowing
☐ Personal hygiene/Grooming
☐ Pushing/Pulling with feet
☐ Pushing/Pulling with hands
☐ Reaching out/up/down
☐ Reading
☐ Running
☐ Seeing
☐ Sewing
☐ Sexual Activity
☐ Shopping
☐ Sitting
☐ Sleeping
☐ Speaking
☐ Stairs
☐ Standing
☐ Standing from seated position
☐ Turning
☐ Twisting
☐ Using the telephone
☐ Walking
☐ Watching TV
☐ Working
☐ Yard Work

☐ B Koenig, DC ☐ T Cox, DC ☐ K Mahlmeister, DC

Patient Name: _____ DOB: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ **DOB**: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Koenig Chiropractic.

Please initial one of the following options and sign below:

___☐___ I wish to receive a paper copy of Privacy Notice.

___☐___ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial all the following options:

___☐___ I acknowledge that it is the policy of Koenig Chiropractic to leave reminder messages on my voice mail or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

___☐___ I acknowledge that it is the policy of Koenig Chiropractic to send text and/or e-mail appointment reminder messages and/or clinic special messages. I may make a request of an alternative means of communication (within reason) in writing.

___☐___ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

SIGNATURE _____ **DATE** _____
Patient/Guardian

.Informed Consent to Care

Informed Consent to Care. A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by that appropriate specialty provider. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider. The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies. I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Physical Rehab, Chiropractic, Shock Wave Therapy, like all forms of health care, offer considerable benefits, at the same time these treatments may produce some level of risk. Although the level of risk for these types of treatments are most often very minimal, in rare cases injury has been associated with chiropractic and physical rehab care. Medical treatment complications are based on the procedure type and any risks associated with treatment will be explained prior to treatment being received. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. The risks are extremely low for acupuncture as well, however possible side effects or complications includes soreness, organ injury and infection. Not everyone makes for a good candidate for acupuncture. Conditions which may increase the risk of complications include bleeding disorders, patients with pacemakers and those who are pregnant.

Prior to receiving Physical Rehab, Chiropractic, Shock Wave Therapy care from this clinic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and particularly your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan as care begins. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor or provider deems necessary, and to the chiropractic are including spinal adjustments, as reported following my assessment.

This notice is effective as of today's date and will expire seven years after the date of which you last received services from this clinic.

Patient Name:_____ Date:_____

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE _____ **DATE** _____

WITNESS _____ **DATE** _____