KOENIG FAMILY CHIROPRACTIC

Family Chiropractic & Therapeutic Rehabilitation Services

Name _____ Date of Birth _____ Age _____ Male/Female

Address _____ City _____ State _____ Zip _____

Email Address _____ Occupation _____

Phone: Cell (_____) _____ Home (_____) _____ Work (_____) _____

Marital Status: Single / Married / Divorced / Widowed Social Security Number _____

Who may we thank for referring you to Koenig Family Chiropractic? _____

Emergency Contact and Relationship _____ Phone (_____) _____

Are you a veteran or first responder (police, fire, EMT, paramedic)? Yes or No

All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. We will gladly provide a detailed superbill if you choose to submit one to your insurance company.

Due to increasing patient volumes, we may have to reschedule your appointment if you are more than 10 minutes late. We have a missed appointment fee for appointments that are not canceled more than 3 hours ahead of time. This fee is $20 for the first offense. Future offenses will be billed at $35 each.

Please be considerate of other patients' and the doctors' time. Please contact us ASAP via phone, text, or email if you cannot make your appointment.

Signature _____ Date _____

Health Profile

CIRCLE ANY CONDITION YOU HAVE EVER HAD:

Stroke	Spinal surgery	Diabetes
Heart disease	Disc issues	Asthma
Heart attack/MI	Spinal bone fracture	Osteoporosis
High blood pressure	Cancer	Epilepsy/seizures

CIRCLE ANY CONDITION YOU HAVE NOW:

Headaches	Knee/leg pain	Scoliosis
Neck pain	Ankle/foot pain	Arthritis
Upper back pain	Arm/shoulder pain	Auto-immune disease
Low back pain	Hand/Wrist pain	Other_____
Hip pain	TMJ	_____

FOR THE ABOVE CONDITIONS, WHICH ONE IS BOTHERING YOU THE MOST?_____

ON A SCALE FROM 0-10, HOW BAD IS THE PAIN IN THAT AREA?_____

IN YOUR OPINION, HOW FLEXIBLE ARE YOU AND YOUR JOINTS? Not flexible Minimal Moderate Very

DO YOU SMOKE OR HAVE YOU EVER SMOKED? YES / NO

ANY AUTO ACCIDENTS IN THE LAST 5 YEARS? YES / NO

LIST ALL SURGICAL OPERATIONS: _____

_____

LIST ALL PRESCRIPTION and OVER THE COUNTER MEDICATIONS YOU TAKE: _____

_____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO **FRACTURED A BONE? YES / NO**

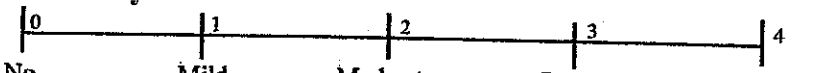
ANY OTHER TRAUMA?_____

Functional Rating Index

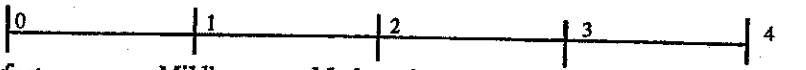
For use with **Neck and/or Back Problems** only.

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

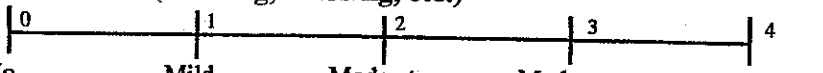
1. Pain Intensity



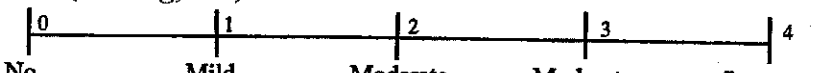
2. Sleeping



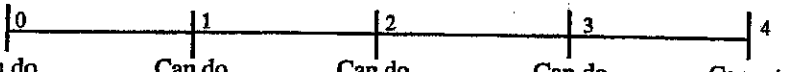
3. Personal Care (washing, dressing, etc.)



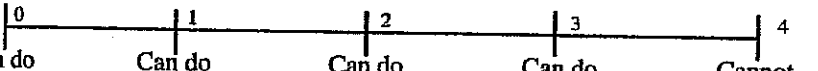
4. Travel (driving, etc.)



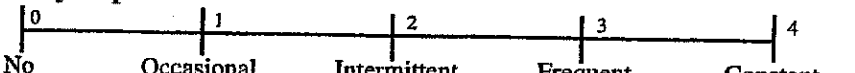
5. Work



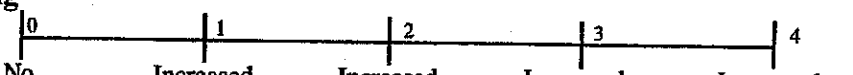
6. Recreation



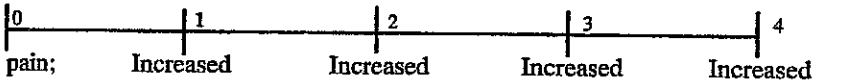
7. Frequency of pain



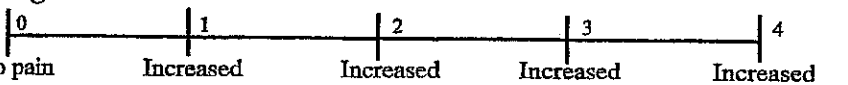
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Part I: _____ Total Score: _____
PRINTED

_____
Signature

_____
Date