APPLICATION FOR CARE AT KOENIG CHIROPRACTIC

Today's Date: _______________

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: _____-_____-_____ Age: _______ ☐ Male ☐ Female

Address: ____ City: _________________________________ State: _____ Zip: ___________

E-mail Address: ____________________________________ Home Phone: _______________________ Mobile Phone: _______________

Employer: ____ Occupation: ____

Name & Number of Emergency Contact: ____ Relationship: ___________________________

Whom may we thank for referring you to the office? ____

HISTORY of COMPLAINT

Is your pain/complaint the result of a motor vehicle accident? ☐ Yes, ☐ No Or accident at work? ☐ Yes, ☐ No

Please identify your pain/complaint that brought you to this office: ____

On a scale of **0** to **10** with **ten** being the worst pain and **zero** being no pain, rate your pain/complaint by ***circling the number***:

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

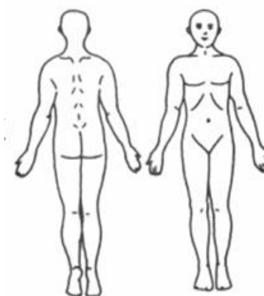
When did the pain/complaint begin? _________________When is the pain/complaint at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does your pain/complaint last? ☐ It is constant **OR** ☐ I experience it on and off during the day

How did the pain/complaint happen? ____

PLEASE MARK the areas on the Diagram with the following **letters** to describe your pain/complaint

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



In the last 2 weeks has anything made your pain/complaint better? ____________________________

In the last 2 weeks has anything made your pain/complaint worse? ____________________________

Have you seen any doctor or health care practitioner for your primary pain/complaint?

Doctor/Health Care Practitioner's Name:	What they did, or prescribed, for you:

Marital Status: ☐ Single ☐ Married

Spouse's Name __________________________________ Spouse's Employer ____

Number of children and ages: ____

What activities are restricted:		YOUR ACTIVITY LEVEL WHEN NOT IN PAIN		YOUR ACTIVITY LEVEL WHEN IN PAIN
Example: Riding my bike :	➡	Usually 25 miles/5 days a week	➡	Maybe 10 miles/2 days a week
1 :	➡		➡	
2 :	➡		➡	

CONTINUED ON BACK OF PAGE. PLEASE TURN OVER TO CONTINUE.

PAST HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*****, C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _________

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ☐cigars ☐ pipe ☐ cigarettes ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

2. Alcoholic Beverage: consumption occurs ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

3. Recreational Drug use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

FAMILY HISTORY:

1. Any other hereditary conditions the doctor should be aware of? ☐ No ☐ Yes: ____________________________________

I hereby authorize payment to be made directly to Koenig Family Chiropractic, INC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Koenig Family Chiropractic, INC for any and all services I receive at this office.

_______________________________________ ______ - ______ - ______

Patient or Authorized Person's Signature **Date Completed**

_______________________________________ ______ - ______ - ______

Doctor's Signature **Date Form Reviewed**