koerner

Chiropractic & Physical Therapy

Patient Information

Date:_____ SSN:_____ Birth date:_____

First Name:_____ Middle Name:_____ Last Name_____

Address:_____

City:_____ State:_____ Zip:_____

Sex (circle one) Male Female Age:_____

Home #_____ Cell #_____

Best time and Place to reach you_____

E-mail:_____

Patient Employer:_____

Occupation:_____

Employer Address:_____

Employer Phone: (_____)_____

Spouse's/Partners name:_____

Spouse/Partner Birth date:_____

Emergency Contact: _____ Emergency Contact Relation: _____

Emergency Phone: _____

Whom may we thank for referring you?_____

INJURY OR ACCIDENT INFORMATION

Is condition due to an INJURY or ACCIDENT? No____ Yes____ Date:_____

Type of accident: Auto: No____ Yes____ Auto Insurance:_____

Claim Number:_____

Work Related: No____ Yes____ Work Comp Insurance_____

Claim Number:_____

Other Accident (lifting, fall, twisting, etc) explain: _____

Attorney Name (if applicable) _____

Do you have Accidental Insurance (i.e. Aflac)? No____ Yes____

Insurance Company and Policy #: _____

Complaint Information

(Please use a separate sheet for each complaint)

Reason for Visit _____

When did your symptoms appear? _____

Since the complaint started, have your symptoms changed: ___No ___Yes (circle one) worse stayed the same better

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain (circle all that apply): Achy / Annoying / Burning / Sharp / Shooting / Dull / Stabbing / Stiffness / Tightness / Throbbing Numbness / Tingling / Swelling / Other _____

Does the pain radiate? ___No ___Yes Explain _____

How often do you have this pain? (circle one): Random On/Off Intermittent Occasionally Frequently Constantly Other _____

Is the pain typically worse in the (circle one): Mornings Afternoons Evenings Night Unknown Other _____

Does it interfere with your: Work Sleep Daily Routine Recreation Other _____

Activities or movements that are painful to perform: Bending / Standing / Sitting / Lying Down / Driving / Changing Positions / Twisting Walking / Turning Head / Looking Up-Down / Work / Exercise / Other _____

Pain relieved by: Nothing Ice Heat OTC Meds Rest Sitting Stretching

Previous Episodes: ___No ___Yes Previous Care: _____

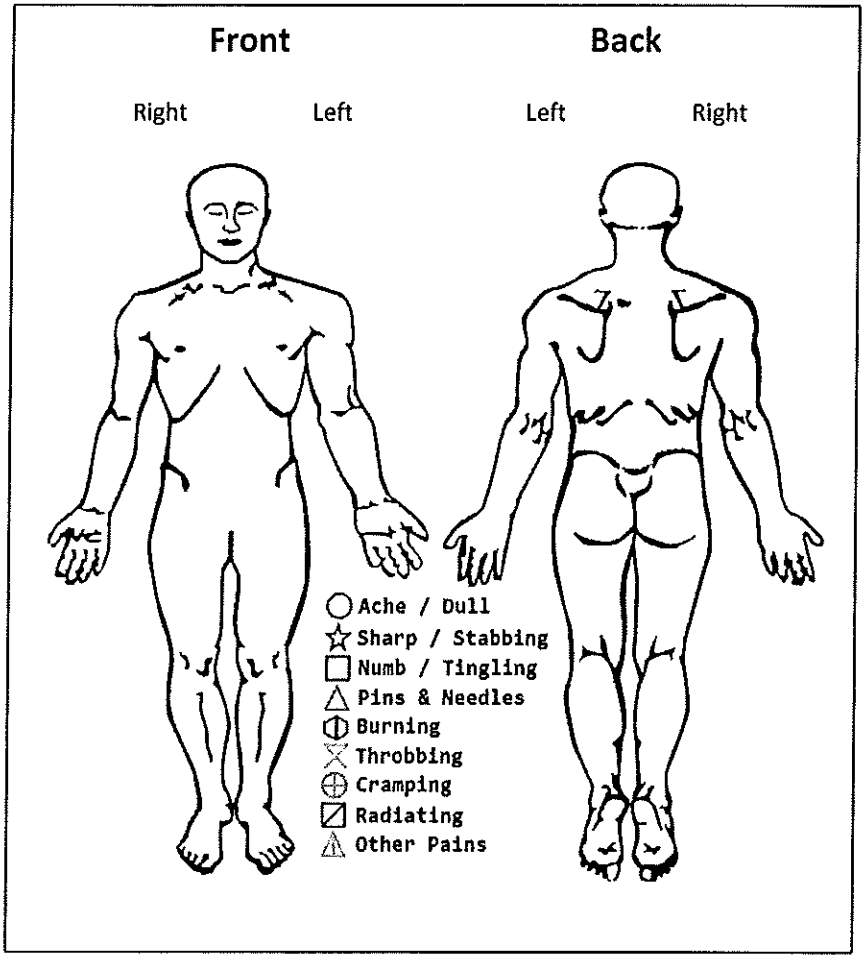
Any Additional Information please explain:

_____

_____

Have you had any of the following treatments for **THIS** condition?

___ Chiropractic
___ Surgery
___ General Practitioner
___ Physical Therapy
___ Medications
___ Neurologist
___ Orthopedist
___ X Ray
___ MRI
___ Injection
___ None
___ Other



HEALTH HISTORY

HAVE YOU HAD ANY OF THE FOLLOW (CIRCLE ALL THAT APPLY)

ALLERGIES	*PROSTATE PROBLEMS*	*HEADACHES*	*OSTEOPOROSIS*	*CONNECTIVE TISSUE DISORDERS*
HEART DISEASE	*GALL STONES*	*ARTHRITIS / SWOLLEN JOINTS*	*PACEMAKER*	*ULCERS*
KIDNEY DISEASE	*GOUT*	*ASTHMA*	*STRESS*	*CANCER (List below)*
HIGH BLOOD PRESSURE	*HIV / AIDS*	*BLOOD DISORDER*	*STROKE / TIA*	*OSTEOPENIA*
LOW BLOOD PRESSURE	*THYROID PROBLEMS*	*SWOLLEN EXTREMITIES*	*CHEST PAIN*	*FATIGUE*
HERNIAS	*RINGING IN EARS*	*RHEUMATOID ARTHRITIS*	*DIABETES*	*JOINT REPLACEMENT*
FIBROMYALGIA	*BLURRED VISION*	*DIZZINESS / FAINTING*	*WEIGHT LOSS/GAIN*	
KIDNEY STONES	*FRACTURES (List below)*	*SEXUAL PROBLEMS*	*MIGRAINES*	
HIGH / LOW CHOLESTEROL	*PAINFUL URINATION*	*MULTIPLE SCLEROSIS*	*WEAKNESS*	

OTHER HISTORY:

_____

_____

HOW OFTEN DO YOU EXERCISE: REGULARLY OCCASIONALLY RARELY NEVER

DO YOU USE TOBACCO: Y / N

IF YES, WHAT KIND _____ **HOW MUCH PER DAY** _____

PLEASE LIST CURRENT MEDICATIONS:

_____

_____

_____

_____

LIST ALL KNOWN ALLERGIES:

_____

_____

LIST ALL MAJOR SURGERIES AND FRACTURES YOU HAVE HAD INCLUDING TYPE AND DATE

_____

_____

_____

_____

PAST HOSPITALIZATIONS: LIST ALL DATES ALONG WITH REASONS:

_____

_____

_____

HISTORY OF PREGNANCY: Y / N

DATES

_____

_____

LIST YOUR PRIMARY CARE PHYSICIAN: _____

DATE OF LAST PHYSICAL EXAM: _____

LIST ANY OTHER INFORMATION YOU WOULD LIKE YOUR DOCTOR / THERAPIST TO KNOW.

_____

_____

_____