

Confidential Patient Information

Name		Date of Birth	Age
Street		City	State
Home phone	Cell/Pager	Zip	
E-mail		S.S.#	

Preferred Language <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other:	Gender <input type="radio"/> Female <input type="radio"/> Male
Race & Ethnicity <input type="radio"/> Black / African American <input type="radio"/> White <input type="radio"/> Asian <input type="radio"/> Hispanic or Latino <input type="radio"/> Native Hawaiian / Pacific Islander <input type="radio"/> American Indian / Alaskan Native	

Patient's Employer	Work phone Ext:		
Street	City	State	Zip

Patient's Insurance	Insured by <input type="radio"/> self <input type="radio"/> spouse <input type="radio"/> parent
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Fill out the following only if policy holder is **different** from patient:

Policy Holder Name	Policy Holder Date of Birth
Policy Holder Employer	Policy Holder Phone
Policy Holder Address	

Referred by <input type="radio"/> Physician <input type="radio"/> Attorney <input type="radio"/> Patient Name: _____ <input type="radio"/> Insurance Company <input type="radio"/> Sign / Location <input type="radio"/> Wake Up Alabama <input type="radio"/> WZZK <input type="radio"/> Yellow Pages <input type="radio"/> Other:
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Past Medical History

Current treating physician (primary, gyn, ob, surgeon, orthopedist, etc.): <input type="radio"/> None	
List previous surgeries and hospitalizations: <input type="radio"/> None	List previous fractures, injuries, accidents? <input type="radio"/> None
Previous spinal or head injury? <input type="radio"/> No <input type="radio"/> Yes	Previous MRI and/x-rays? <input type="radio"/> No <input type="radio"/> Yes
Previous spinal or joint injections? <input type="radio"/> No <input type="radio"/> Yes	Bone density exam (DEXA)? <input type="radio"/> No <input type="radio"/> Yes
Previous PSA test? (males) <input type="radio"/> No <input type="radio"/> Yes	Previous chiropractic care? <input type="radio"/> No <input type="radio"/> Yes

Notes:

poro/penia
Tscore:

Social History

<input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Widow <input type="radio"/> Divorced <input type="radio"/> Significant Other	Children? <input type="radio"/> None How many?
Occupation: <input type="radio"/> Home <input type="radio"/> Unemployed <input type="radio"/> Student <input type="radio"/> Part time <input type="radio"/> Full time <input type="radio"/> Retired	Frequent bending & lifting? <input type="radio"/> No <input type="radio"/> Yes
Diet: <input type="radio"/> Poor <input type="radio"/> Good <input type="radio"/> Excellent <input type="radio"/> Vegetarian	Exercise: <input type="radio"/> None <input type="radio"/> Occasional <input type="radio"/> Regular
Smoking: <input type="radio"/> Never <input type="radio"/> Quit <input type="radio"/> Current	Alcohol: <input type="radio"/> No <input type="radio"/> Social <input type="radio"/> Heavy <input type="radio"/> In recovery
Energy level? <input type="radio"/> Low <input type="radio"/> Moderate <input type="radio"/> High	High stress? <input type="radio"/> No <input type="radio"/> Yes
Illicit drug use? <input type="radio"/> No <input type="radio"/> Yes	Wear seatbelt? <input type="radio"/> No <input type="radio"/> Yes
List drug allergies: <input type="radio"/> None	Pregnant? <input type="radio"/> No <input type="radio"/> Birth Control <input type="radio"/> Trying <input type="radio"/> Yes
List current prescription drugs: <input type="radio"/> None	

Quit Date:
Packs:

Due Date:

Family History

Check all that apply to your mother, father, or siblings:

- Cancer Heart Disease Depression Diabetes Hypertension Stroke Alzheimer's
 Asthma Osteoarthritis Rheumatoid Arthritis Migraine Osteoporosis Unknown /Adopted

Review of Systems

Check all that apply to you:

General / Constitutional

- Weight change Night sweats Appetite change Sleep change Energy change None

Eye, Ear, Nose, Mouth, Throat

- Vision change Light sensitivity Pain Redness Tearing Dryness None
 Hearing loss Ear ringing Ear pain Vertigo/Dizziness Sore throat Swollen glands
 Congestion Nose bleeding Gum/tooth pain None

Cardiovascular

- Chest pain/pressure Heart flutter Pain with breathing Wake gasping Leg/ankle swelling
 Cold hands/feet Leg pain with walking None

Respiratory

- Breathing difficulty Wheezing Cough None

Gastrointestinal

- Abdominal pain Nausea Vomiting Heartburn/Reflux Difficulty swallowing
 Constipation Diarrhea Urgent bowels Excessive gas Blood in bowels None

Genitourinary

- Urine change Menses change Libido change Pelvic pain Erectile dysfunction None

Musculoskeletal

- Joint swelling Joint tenderness Joint stiffness Joint redness Muscle pains None

Skin

- Recent changes Rash Lumps Itching Nail changes None

Neurological

- Headache/Migraine Weakness Tremors Tingling Numbness None

Psychological

- Confusion Nervous/Restless/Anxious Depressed Memory change None

Endocrine

- Temperature intolerance None

Blood / Lymph / Immunological

- Easy bruising Easy bleeding Swollen lymph nodes: (Neck Arm pits Groin) None
 Recent fevers Persistent cough Repeat infections Swelling None

Notes:

Wt: inc / dec
Ap: inc / dec
SI: inc / dec
En: inc / dec

V: acc/ blur/ 2x/ peri L R B

Loss: L R B
Ring: L R B
Pn: L R B

LegP: L R int / con

C: product / heme

U: dys / hem / noc / poly / urg /
U: inc / dec
M: amen / dys
L: inc / dec

LOC: sh / elb / wr / hand / hip/
kn / ank / foot / fing / toe / heel

HA: con/ int L R B F T O
W: lue/ rue/ lle/ rle
T/N: lue/ rue/ lle/ rle

App: inc/dec

Inf: bladder/ skin/ chest/ head

Chronic Illness List Check all that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> OADHD | <input type="checkbox"/> OFibromyalgia |
| <input type="checkbox"/> OGout | <input type="checkbox"/> OAnemia |
| <input type="checkbox"/> OHepatitis | <input type="checkbox"/> OGERD / Heartburn |
| <input type="checkbox"/> OOsteoarthritis (degenerative) | <input type="checkbox"/> ORheumatoid Arthritis |
| <input type="checkbox"/> OHIV / AIDS | <input type="checkbox"/> OProstate Enlargement |
| <input type="checkbox"/> OAsthma | <input type="checkbox"/> OHiatal Hernia |
| <input type="checkbox"/> OHigh Cholesterol (Hyperlipidemia) | <input type="checkbox"/> OHigh Blood Pressure (Hypertension) |
| <input type="checkbox"/> OCongestive Heart Failure | <input type="checkbox"/> OHypothyroidism / Hyperthyroidism |
| <input type="checkbox"/> OCarpal Tunnel Syndrome | <input type="checkbox"/> OKidney Disease |
| <input type="checkbox"/> OColitis | <input type="checkbox"/> OMigraines |
| <input type="checkbox"/> OCoronary Artery Disease | <input type="checkbox"/> OMVP / Mitral Valve Prolapse |
| <input type="checkbox"/> OCOPD | <input type="checkbox"/> OSleep Apnea |
| <input type="checkbox"/> OCrohn's Disease / IBS | <input type="checkbox"/> OOsteoporosis / Osteopenia |
| <input type="checkbox"/> OCVA / Stroke | <input type="checkbox"/> OPVD / Peripheral Vascular Disease |
| <input type="checkbox"/> ODepression | <input type="checkbox"/> ORLS / Restless Leg Syndrome |
| <input type="checkbox"/> ODiabetes Type II | <input type="checkbox"/> OCancer: Opast Ocurrent |
| <input type="checkbox"/> OOTHER: | |

Notes:

LOC:

Initial:

Patient signature	Date
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History of Present Condition

PROBLEM	<input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist/Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle/Foot
	<input type="checkbox"/> Headache Other:

Notes:

How long have you had this problem?	
Current status	<input type="checkbox"/> Currently experiencing <input type="checkbox"/> Not experiencing today
Context	<input type="checkbox"/> Stable /unchanging <input type="checkbox"/> better/improving <input type="checkbox"/> getting worse <input type="checkbox"/> fluctuating
Cause	<input type="checkbox"/> Trauma/injury <input type="checkbox"/> No trauma/injury <input type="checkbox"/> Unknown
Location	SEE PICTURE
Radiation	<input type="checkbox"/> None <input type="checkbox"/> left arm/leg <input type="checkbox"/> right arm/leg <input type="checkbox"/> Upper back <input type="checkbox"/> Head
Onset	<input type="checkbox"/> Sudden <input type="checkbox"/> gradual
Severity	<input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild
Quality	<input type="checkbox"/> Sore/tender <input type="checkbox"/> Ache <input type="checkbox"/> Dull <input type="checkbox"/> Throb <input type="checkbox"/> Sharp <input type="checkbox"/> Diffuse/ill-defined <input type="checkbox"/> Stab <input type="checkbox"/> Numb <input type="checkbox"/> Tingle <input type="checkbox"/> Burn <input type="checkbox"/> Shooting <input type="checkbox"/> Tearing <input type="checkbox"/> Spasm <input type="checkbox"/> Pressure-like <input type="checkbox"/> Weak <input type="checkbox"/> Tight <input type="checkbox"/> Stiff <input type="checkbox"/> Lost motion <input type="checkbox"/> Other
Frequency	<input type="checkbox"/> Rare <input type="checkbox"/> 25% of time <input type="checkbox"/> 50% of time <input type="checkbox"/> 75% of time <input type="checkbox"/> 100% of time
Worsens / Triggers	<input type="checkbox"/> Nothing <input type="checkbox"/> Lifting <input type="checkbox"/> Moving <input type="checkbox"/> Walking <input type="checkbox"/> Laying <input type="checkbox"/> Bending <input type="checkbox"/> Sitting <input type="checkbox"/> Get up from bed/chair <input type="checkbox"/> Cough/sneeze <input type="checkbox"/> Other
Helps / Alleviates	<input type="checkbox"/> Nothing <input type="checkbox"/> Rest <input type="checkbox"/> Ice <input type="checkbox"/> Heat <input type="checkbox"/> Laying <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Aspirin/ibuprofen/Aleve <input type="checkbox"/> Tylenol <input type="checkbox"/> Other
NSAIDs (aspirin, etc)	<input type="checkbox"/> No pills taken <input type="checkbox"/> Helpful <input type="checkbox"/> Mildly helpful <input type="checkbox"/> Not helpful
Other treatments tried for this condition	<input type="checkbox"/> None <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Over-the-counter meds <input type="checkbox"/> Physical therapy Other:
Past treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Related symptoms	

a s c

pm pn
weak/PE
saddle
bo/bl
dysuria
fever

Patient signature	Date
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Initial _____

Symptom Drawing & Borg Pain Scale

1

Draw your symptoms¹ using the following symbols:

XXXX= Pain

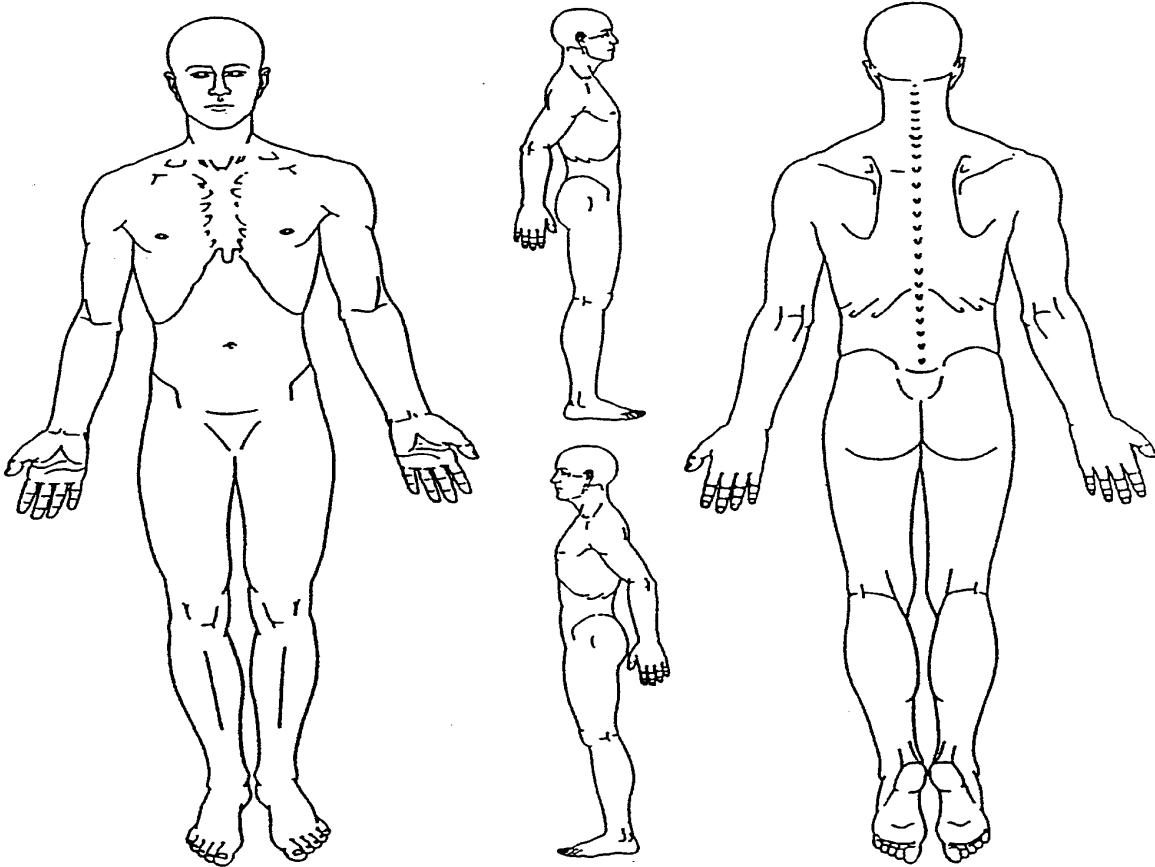
OOO = Numb

TTT = Tingle

///// = Burn

≈≈≈ = Spasm

SSS = Stiff



2

Mark your current level of discomfort²:



3

Signature

Date

¹ Ransford AD, Cairns D. Mooney V: The Pain Drawing as an Aid, Spine 1(2): 127-134, 1976.

² Borg Pain Scale

Consent to Treatment & Financial Policies

Consent to Treatment

I authorize Koenig Wellness to perform diagnostic tests, including radiographs, and to administer treatment, including joint manipulation and physiotherapy, on me (or on the minor patient for whom I am legally responsible) as deemed necessary.

I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result does not necessarily indicate an error in judgment.

I have also been advised that although the incidence of complications associated with chiropractic services is extremely low, anyone undergoing manipulative procedures, physiotherapy or rehabilitation should know the possible hazards and complications which may be encountered or result. These include, but are not limited to, fractures, disk injuries, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetected by the doctor. I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim and certify that all insurance information given is correct and full.

Authorization for Payment to Provider of Care

I authorize/request my insurance company or attorney to pay directly to Dr. Jason J. Koenig, P.C. (Koenig Wellness) the expense benefits allowable and payable to me under my current policy or settlement, as payment toward the total charges for services rendered. I agree that this office be given limited power of attorney to sign my name on any drafts for payment of my bill.

Financial Policies

I understand and agree that insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt.

In some cases payment may be expected at the time of service including co-payments, deductibles and fees for non-covered services. We have never denied anyone the benefits of care in our office because of an inability to pay our published fees. Special arrangements must be worked out prior to initiating care. Outstanding balances are billed monthly and as closely as possible reflect remainder balances following a response from the insurance carrier. We accept cash, check, credit card, and bank cards.

I understand and agree that I am ultimately personally responsible for payment of all services rendered to me and I am responsible for any costs, consisting of court, collection and attorney fees if a collection procedure is necessary to satisfy my bill.

I understand returned checks are subject to a fee of what the bank charges this office plus \$20.00.

I understand that I may be charged \$35 for a missed scheduled appointment without a 24 hour notice.

Acceptance Signature

I have read, clearly understand and agree to these policies.

Signed _____
Patient / Responsible Party

Date _____

Signed _____
Office Representative

Date _____

Privacy Policies

I, hereby state that by signing this Consent, I acknowledge and agree as follows:

I have been informed about and given the chance to read the Notice of Privacy Practices. The Notice includes a complete description of the uses and/or disclosures of my Private Healthcare Information (PHI) necessary for Dr. Jason J. Koenig, P.C. (d.b.a. Koenig Wellness) to provide treatment to me, obtain payment for that treatment and to carry out healthcare operations. Koenig Wellness reserves the right to change its privacy practices in accordance with applicable law.

I understand that, and consent to, the following communications that will be used by Koenig Wellness:

- a. Postcards or letters mailed to me at the address provided by me; and
- b. Telephoning my home or office and leaving a message on a voice answering machine or with the individual answering the phone; and
- c. E-mailing me at the address provided by me; and
- d. Recognizing special events, referrals given, and similar information in Koenig Wellness publications including the Koenig Wellness website, newsletters and in-office postings

I understand that this Consent is valid for (7) seven years. I further understand that I reserve the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that Koenig Wellness has already taken action in reliance on this consent.

I understand that if I refuse to sign or revoke this Consent at any time, Koenig Wellness has the right to refuse to treat me.

I give Koenig Wellness permission to share my PHI with the following individuals when necessary: None

I have read and understand this Consent, and all of my questions have been answered.

Signed _____
Patient / Responsible Party

Date _____

Signed _____
Office Representative

Date _____