Welcome To Konopka Chiropractic PLLC

Thank you for chosing Konopka Chiropractic for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We are happy to help.

Patient Information:

Name: Email:

Address: City:

State: Zip Code:

Birthdate: SS#

Sex: ( )Male ( )Female ( )Married ( )Single ( ) Minor ( )Widowed ( )Separated ( )Divorced ( )Partnered for years

Home Phone: Cell Phone: Work Phone:

Would you like to receive text messages for Appointments Scheduled? ( ) YES ( ) NO

Employer: Occupation:

Employer Address: Employers Phone #:

Spouse's or Parent's Name: Emergency Contact: Phone#:

Whom may we thank for referring you?

Insurance Information:

Insurance Company:

Subscriber's Name: Birthdate: SS#

Relationship to Subscriber:

ID# Group# Secondary Insurance? ( )Yes ( )No

Health History:

Circle only those conditions which are applicable:

AIDS/HIV	Alcoholism	Allergy Shots	Anemia	Anorexia	Appendicitis	Arthritis	Asthma
Bleeding Disorders	Breast Lumps	Bronchitis	Bulimia	Cancer	Catarcts	Chem. Dependency	Chicken Pox
Depression	Diabetes	Emphysema	Epilepsy	Fractures	Glaucoma	Goiter	Gonorrhea
Gout	Heart Disease	Hepatitis	Hernia	Herniated Disc.	Herpes	High Cholesterol	Kidney Disease
Liver Disease	Measles	Migraine Headaches	Miscarriage	Mononucleosis	Multi.Sclerosis	Mumps	Osteoporosis
Pacemaker	Parkinson's Disease	Pinched Nerve	Pneumonia	Polio	Prostate Problems	Prosthesis	Psychiatric Care
Rheumatoid Arth.	Rheumatic Fever	Scarlet Fever	Stroke	Suicide Attempt	Thyroid Problems	Tonsillitis	Tuberculosis
Tumors/Growths	Typhoid Fever	Ulcers	Vaginal Infect.	Venereal Disease	Whooping Cough	Other:_____	

Date of last Exam: **(Female) Pregnant?** ( )Yes ( )No **Taking Birth Control Pills?** ( )Yes ( )No

List Injuries/Surgeries you have had with dates:

Medications/ Allergies/Vitamins/Herbs:

Exercise: ( )None ( )Moderate ( )Daily ( )Heavy

What Treatment have you received for your condition? ( )Medications ( )Surgery ( )Physical Therapy ( )Chiropractic Adjustments ( )None

Which activities are difficult to perform? ( )sitting ( )Standing ( )Walking ( )Bending ( )Lying Down

Authorization

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

X

Signature of Patient (or parent of minor) **Date:**