Michael C. Kennedy, D.C.

Personal and Health History

Today's Date: _____
Name: _____SS#_____
Date of birth: _____Age:_____ Sex: M / F Ht: _____Wt:_____
Address: _____
City: _____State: _____ Zip Code: _____
Home phone: _____ Cell phone: _____Work Phone: _____
Marital Status: Single / Married / Divorced / Widowed
No. of children: _____
Patient Employer: _____ Patient type of work:_____
Work phone number:_____
Patients Insurance:_____
Spouses Name (if on spouses insurance) _____Spouses Date of Birth _____
Who is responsible for your bill: Self / Spouse / Work Comp / Auto Ins / Medicare / Private Ins / Other
How did you hear about Michael C. Kennedy, D.C.?_____

Current Health History

Purpose of this visit ? _____
Major complaint ? _____
When did this condition begin?_____
Are there others in your family with this condition?_____
If disabled from work, please give dates:_____
Job related? Yes/No
Auto related? Yes/No Date of accident/injury:_____
Medications you are currently taking?_____
Over the counter drugs you are currently taking:_____

Past Medical History

Please check or describe:
Any operations ?_____
Appendix:_____Tonsils:_____Gall Bladder:_____Hernia:_____
Heart:_____Back:_____Neck:_____Leg:_____Other:_____
Have you had any major accidents or falls? Yes/No
If yes, please describe:_____
Hospitalizations other than the above?_____
Have you had any previous chiropractic care? Yes/No
If yes, please give Doctors name and approximate time of visits:_____
Have you been treated for any health problems in the past year? Yes/No
If yes, please explain:_____
Does anyone else in your family have the same or similar condition? Yes/No
If yes, please explain:_____

_____
Date Patient Signature

Doctors Initials_____

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Below are lists of diseases which may seem unrelated to the purpose of your visit. However, these questions must be answered carefully as these problems can affect the overall course of chiropractic care. Check any of the following diseases you have had:

__Pneumonia
__Rheumatic Fever
__Polio
__Tuberculosis
__Whooping Cough
__Anemia
__Mumps
__Small pox
__Chicken pox
__Diabetes
__Cancer
__Heart Disease
__Influenza
__Pleurisy
__Arthritis
__Epilepsy
__Mental Disorder
__Lumbago

Intake

__Coffee
__Tea
__Alcohol
__Cigarettes
__White Sugar

Female/Male Code

__Menstrual Irregularity
__Menstrual cramping
__Vaginal Pain/Infection
__Breast Pain/Lumps
__Prostate/Sexual Dysfunction

Females Only

When was your last period?

_____

Are you Pregnant? Yes / No / Unsure

Check any of the following that you have had in the past six months:

Musculo-Skeletal

__Low back pain
__Pain between shoulders
__Neck pain
__Arm pain
__Leg pain
__Shoulder pain
__Knee pain
__Joint pain/stiffness
__Problems Walking
__Difficulty chewing/clicking jaw
__General stiffness
__Headache

Nervous system

__Nervous
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion/depression
__Convulsions
__Cold tingling extremities
__Stress

Gastro-Intestinal

__Poor/excessive appetite
__Excessive thirst
__Frequent nausea
__Vomiting
__Constipation
__Hemorrhoids
__Liver problems
__Gall bladder problems
__Black tarry stool
__Colitis
__Abdominal cramps
__Gas/bloating after meals
__Heartburn
__Weight problems

General Code

__Fatigue
__Allergies
__Loss of sleep
__Fever

_____

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Genital/Urinary code

__Bladder trouble
__Painful/excessive urination
__Discolored urine

EENT code

__Vision problems
__Dental problems
__Sore throat
__Earaches
__Hearing difficulty
__Stuffy nose

C-V-R code

__Chest pain
__Shortness of breath
__Blood pressure problems
__Irregular heartbeat
__Heart problems
__Lung problems/lung congestion
__Ankle swelling
__Varicose veins
__Stroke

Why Chiropractic?

People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms arrested and relieved (corrective care). Still, others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (preventative care).
These are three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, his recommendation is an incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

__Relief care __Corrective care __Preventative care
__Check here if you want the doctor to select the type of care appropriate for your condition.

Date: _____
Patients signature: _____
In Case of emergency, please call: _____
Phone number: _____

Doctors Initials_____

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