KENNEDY CHIROPRACTIC
HEALTH & WELLNESS CENTER

11 MAREBLU, SUITE 120
ALISO VIEJO, CA 92656

Patient Health History

How did you find us?
Smoke signal | Luck | Yelp | Intuitive power | Friend
If it was a "Friend," who may we thank?

_____

Welcome to Kennedy Chiropractic Health & Wellness Center, and congratulations on wanting to be the very best version of yourself! Thank you for choosing us, and we look forward to making your health goals an achievable reality! Please fill out this form as accurately as possible, as it will help Dr. Kennedy determine the best course of treatment for your particular issue.

PATIENT INFORMATION:

Name:_____E-mail:_____

Street Address:_____City:_____Zip:_____

Home Ph.:(_____)_____Cell Ph.:(_____)_____ Carrier: At&t/Verizon_____

Preferred method of contact? Text | Phone | email

Date of Birth:_____/ _____/ _____ Social Security#_____/ _____/ _____

Age:_____ Sex: *Male* | *Female* Height:_____Weight:_____Smoke: Y | N Drink: Y |N

Marital Status: Single, Married, Divorced, Widowed # of Children & ages:_____

Employer:_____Occupation:_____Hours per week:_____

Spouses name:_____Occupation:_____

PERSONAL INJURY:AUTO ACCIDENT:

Date of Injury:_____Time:_____am/pm Describe what happened**:**_____

_____

Insurance Co.:_____Pol.#_____Claim#:_____Tel.#: (_____)_____

What car were you driving?_____Their car?_____Air Bag deploy: Yes | No

Approx. speed:_____mph Passengers in Car with you:_____Police report: Yes No (circle one)

Taken By Ambulance: Yes No (circle one) Hospitalized?_____X-rays, MRI's, CT's?_____

Time lost from work?_____ Seat Belted? Yes | No (circle one) Loss of Consciousness: Yes | No

Name of Atty:_____Phone #(___)_____ Doctor's seen to date:_____

MAJOR COMPLAINTS

What are your **primary complaints today** | or major health concerns?_____

_____

When did complaints begin?_____**How** did complaints begin?_____

On a scale of 1-10 (ten being the worst) what is your pain **now**?_____ When it is the **worst**?_____Best?_____

What causes the pain to become **worse**?_____

What causes the pain to become **better**?_____

Does your **pain travel away** from the point of origin? Yes | No (circle one) Where to? _____

How would you describe your pain? Dull | Sharp | irritating | _____

Have you seen any **other medical professional** for this same condition?_____

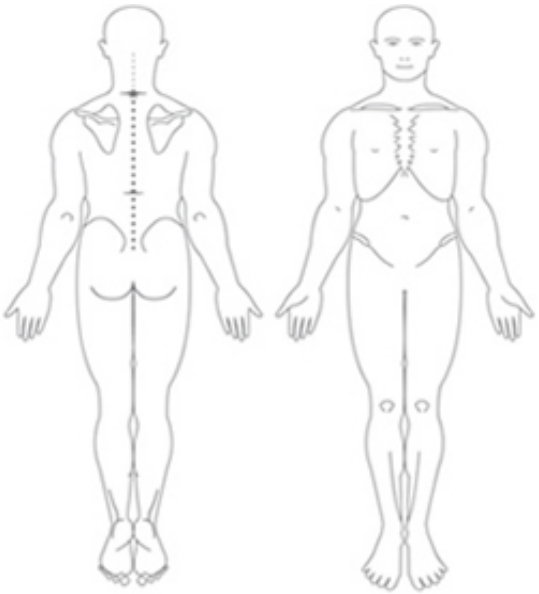
What treatment was provided?_____How long?_____How many Treatments?_____

What has **helped** the most in caring for your condition?_____

Are you currently taking any **medications**?_____

Any **health issues** you are being treated for presently?_____

Allergies?_____Past Surgeries?_____



Please mark where you have pain and/or:

Stabbing	Numbness
=====	/////////
Burning	Trigger Points
^^^^	+++++++
Sharp	Dull/Achy
OOOOO	▲▲▲▲▲

Medical History

- ❑ Arthritis
- ❑ Allergies/hayfever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Brorchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ BPH
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ STD

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ PMS
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ STD

Other _____

Age of first period _____

Date of last gynecological exam ____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

- ❑ Surgical menopause
- ❑ Menopause

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (parents and siblings)

- ❑ Arthritis, rheumatoid
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d_____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (e.g., Ensure)

Other _____

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

What is your philosophy of health? (What do you believe constitutes good health for you?)

_____

How do you want us to handle your health problem?

_____**Relief/REACTIVE Care** (Help the symptoms, but does not fix or address the cause of the problem)

_____**Wellness/Preventative/Corrective Care** (addressing symptoms, while correcting the cause of the problem for maximum stability and performance in the future)

ON A SCALE OF 1-10 (10 = being the most committed, 1 = being the least committed), How committed are you to:

_____Following through with discipline in showing up for appointments and partnering in your own healing?

_____Not allowing your own justifications, excuses and half-hearted attempts to be ***obstacles*** to your healing?

_____Being patient with the healing process, and being committed to our partnership in helping you reach your goals?

____Not giving up on yourself, and seeing this injury through to the other side of healing?

FINANCIAL AGREEMENT AND INFORMED CONSENT

I understand that health and accident policies are an arrangement between my insurance company and me. As a courtesy, *Kennedy Chiropractic Health & Wellness Center*, will gladly bill any eligible policy that I may have. However, regardless of coverage limitations or exclusions, I agree that I am completely financially responsible for all charges incurred on my account. Regarding Health Insurance: We will accept assignment of insurance benefits upon verification of eligible benefits. At the time of service, your co-payment (insurance portion) and/or yearly deductibles are due at the time services are rendered. The balance of your account is your responsibility whether your insurance company pays or not.

IMPORTANT: As we are out of network with your insurance (except for Blue Shield), there is the distinct possibility—that YOU THE PATIENT—will be mailed explanation of benefits with CHECKS addressed to you instead of Kennedy Chiropractic. Therefore, it is your responsibility to sign over the checks, and either send by mail, or bring them with you when you come for treatment. For your convenience, we will also send out audits of checks you will have received with stamped envelopes to make it easier for you and more efficient. *As a safeguard against non-compliance, we will also take a copy of your CC, and if checks have not been received, you give us permission to make payment on the CC for the exact amount the check was made payable to you for.*

Signed_____Date_____