

KENWOOD CHIROPRACTIC

HISTORY CONSULTATION

Name _____ Date _____

List your chief complaint and any associated symptoms or conditions

- A. _____ D. _____
B. _____ E. _____
C. _____ F. _____

How long have you had the complaint(s)?

Are they due to any type of injury? No Yes (give date) Describe Your Injury _____

Have you ever had a blow to your: Head? Tailbone?

Prior to the problem beginning did you ever have an earlier problem that was the same or similar?

Yes No Explain: _____

Did your present problems appear Slowly? Immediately? After some trauma?

Does any family member have this problem or a similar one? _____

How often does it bother you now? _____

When your chief complaint is at it's worst, how does it interfere with your normal daily activities? _____

Does your chief complaint reduce your productivity or effectiveness regarding your work? _____

Does it create any problems in your relationships? Yes No

If yes, how? _____

What aggravates the problem? _____

What makes it better? _____

What other treatment / therapy have you tried that has been unsuccessful? _____

How does this condition make you feel? _____

If your problem was left unhandled for five years, how do you think it would affect you? _____

Are you committed to getting rid of not only your symptom(s) but what had caused it, even if it requires a change in your lifestyle? Yes No

Previous chiropractic care? Yes No If yes, where? _____

Are you taking any medication? _____

Are you under any other treatment for this or any other condition? _____

List all previous surgeries: _____

List all previous accidents: _____

Name: _____

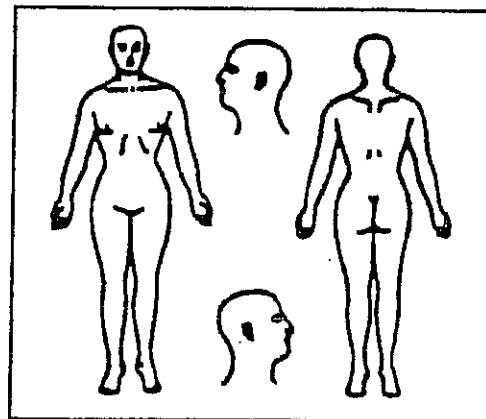
IF YOU HAVE ANY DIFFICULTY WITH THE FOLLOWING PLEASE INDICATE WITH AN X:

- Headaches
- Shooting head pains
- Loss of smell
- Hayfever
- Asthma
- Loss of taste
- Tightness of throat
- Inflammation of throat
- Thyroid trouble
- Face flushed
- Twitching of face
- Loss of memory
- Fatigue
- Dizziness
- Fainting
- Loss of balance
- Ringing in ears
- Wear glasses
- Lights bother eyes
- Muscle spasms in neck
- Grating in neck

- Tightness of shoulder muscles
- Neuritis in shoulders and arms
- Pins and needle in arms and hands
- Cold hands
- Chest pains
- Shortness of breath
- T.B.
- Heart Pain
- Heart palpitation
- Heart attacks
- High blood pressure
- Low blood pressure
- Anemia
- Rheumatic fever
- Nervous stomach
- Stomach trouble
- Ulcers
- Nerves and nervousness
- Inner tension
- Irritability
- Cold sweats

- Liver trouble
- Gall bladder trouble
- Indigestion
- Intestinal gas
- Constipation
- Kidney trouble
- Bladder trouble
- Menstrual cramps and pain
- Diabetes
- Cancer
- Sleeping problems
- Painful joints
- Swollen joints
- Arthritis
- Slipped disc.
- Pinched nerves in back
- Pins and needles in legs
- Swollen ankles
- Cold feet
- Pains in legs and feet

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



H/S	_____
AL	_____
SM	_____
VIT	_____
DIET	_____
EX	_____

KENWOOD CHIROPRACTIC ARTS

APPLICATION FOR TREATMENT (Confidential)

Date: _____ Social Security No.: _____

Name: _____ Age: _____ Birthdate: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cellular/Pager: _____

E-mail: _____ Occupation: _____ Text o.k. Y or N

Employer's Name and Address: _____

Name of spouse or significant other: _____

Place of Employment: _____ Phone: _____

Who may we thank for referring you to us? _____ Phone: _____

Who may we contact in case of emergency? _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

I have read and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Date: _____
Patient Signature

Date: _____
Parent or Guardian (if minor)

Social Security Number