KENNEDY CHIROPRACTIC
HEALTH & WELLNESS CENTER

11 MAREBLU, SUITE 120
ALISO VIEJO, CA 92656

Patient Health History

Welcome to Kennedy Chiropractic Health & Wellness Center, and *congratulations* on taking control of your health! Thank you for choosing us! We look forward to making your health goals a reality! Please fill out this form as accurately as possible, as it will help the doctor to determine an adequate course of treatment for your particular issue.

Referred by:_____

Patient Information:

Name:_____E-mail:_____

Street Address:_____City:_____Zip:_____

Home Ph.:(___)_____Cell Ph.:(___)_____Work Ph.:(___)_____

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

Age:_____ Sex: Male Female (circle one) Height:_____Weight:_____Smoke:_____Drink:_____

Marital Status: Single, Married, Divorced, Widowed (Circle one) Children:_____

Employer:_____Occupation:_____Hours per week:_____

Spouses name:_____Occupation:_____Hours per week:_____

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 (circle one)
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_____

Major Complaints

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

_____

When did it begin?_____**How** did it 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? _____

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

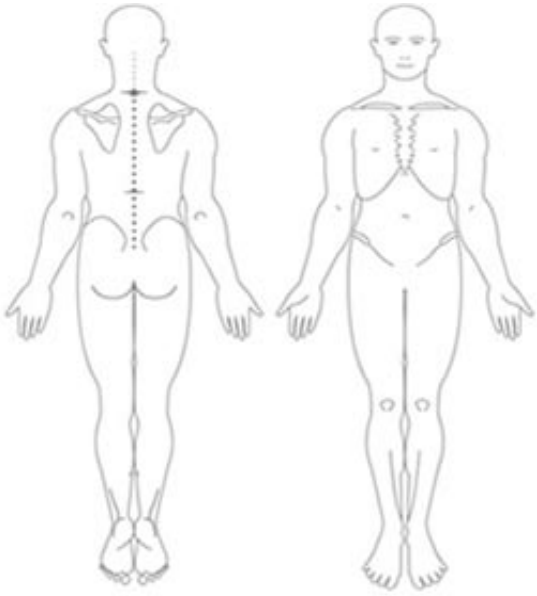
What treatment was provided?_____How long?_____How many Treatments?_____

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

Numbness
=====

Stabbing
/////////

Burning
^^^^

Trigger Points
+++++++

Pins & Needles
XXXXX

Medical History

- ☐ Arthritis
- ☐ Allergies/hayfever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ 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 Care(Help the symptom, but does fix or address the cause of the problem)

_____Wellness/Corrective Care (Correct the cause of the problem for maximum stability in the future)

On a scale of 1-10 (Ten being the most, one being the least), how committed are you to:

_____Achieving your maximum health potential?

_____Living and being your Best?

_____Preventing illness and maximizing your body's ability to create balance in all areas

Financial Agreement

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 and 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.

Please note: 1) Full payment is due at time of service 2) We accept cash, Checks, MasterCard, Visa or Debit 3) We offer Care Credit for those with good credit and can be interest free up to one year! For all cash plans and early termination: Reimbursement will be given minus full price of services rendered to date.

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.

Signed_____ Date_____

Informed Consent:

Chiropractic: **I hereby request and consent to the performance of conservative treatments to joints and soft tissues.**
I understand that the procedures may consist of manipulations and adjustments, which consists of a specific force to a joint within the body. Rehabilitative exercise and therapeutic activities may also be employed during the course of treatment.
I am informed and understand that, as in the practice of medicine, there are some risks associated with chiropractic treatment. Although spinal manipulation is considered by many peer-reviewed studies to be one of the safest, most effective forms of treatment for musculoskeletal problems, there are some risks which are rare, but include and are not limited to: soreness; fractures; disc injures, and in rare cases, vascular insufficiency leading to stroke. I understand that results are not guaranteed.

Acupuncture: **I hereby request and consent to the performance of conservative treatments which are within the scope of practice pertaining to acupuncture and oriental medicine. I understand that the procedures may or may not consist of the use of needles of varying lengths, moxibustion, cupping, Gua Sha, Herbology and physiotherapy. I understand that results are not guaranteed. I am informed and understand that, as in the practice of medicine, there are some risks associated with acupuncture treatment, included but not limited to: discomfort at the needle site, bruising, slight bleeding, nausea, infection and blisters. I also understand that some herbs may be contraindicated during pregnancy and I will inform my doctor should this happen.**

I have read the above statements in their entirety. My signature below signifies my agreement to the above. I intend this consent form to cover the totality of treatment which I shall receive for the health issue which I have sought treatment for, as well as for subsequent treatments that are rendered to me by this facility. I acknowledge that I have completed this health history accurately and to the best of my ability.

Signed_____ Date_____