KehoeFamily Chiropractic

Chiropractic is the science, philosophy and art that utilizes the *inherent recuperative powers* of the body to *heal itself* without the use of drugs or surgery.

Welcome to our office. Help us get to know you.

Name:	**Preferred Name:**
Address: City State Zip	
Date of Birth:	**Email Address:**
Phone Number: Home or Cell	
How would you like to receive complimentary appointment reminders? TEXT EMAIL CALL None Needed **If text is requested, what company do you use as your cell phone carrier?**	
Occupation:	**Employer:**
How do you spend most of your work day? Sitting Walking Standing Laboring Other	
Relationship status: Married Separated Divorced Widowed Engaged Single Other	
Name of Emergency Contact: **Relationship to you:**	**Phone Number:**

Lifestyle Habits:

Please circle all that apply & specify amounts:	**Drink Coffee_____**	**Drink Soda _____**	**Tobacco Use _____**
	Drink Tea _____	**Use Artificial Sweeteners _____**	
	Drink Alcohol _____	**Recreational Drugs _____**	

How much water do you drink/day?	**What do you do for exercise?** **How Often: Daily _____x Weekly** **I don't exercise regularly**
How would you describe your diet? Poor Fair Adequate Good Excellent	
Are you on a special diet? (Paleo Vegetarian Dairy Free…)	**# Fruits & Vegetables/Day**
Have you recently been vaccinated? YES NO If yes, for what?	

Medications (include over the counter)	For what condition	Taken how long
Vitamins /Supplements/ Herbs		

Healthcare History

Healthcare practitioners you have seen in the last year			
Name	**City**	**Last Visit**	**Reason for your visit**

List ALL Surgeries/Hospitalizations		
Type	**Date**	**Recovery outcome?**

Below is a list of symptoms. Please check if you have had or are currently suffering from any of the following:

Past	Symptom	Present
	neck pain	
	headaches	
	shoulder pain	
	breathing troubles	
	cold extremities	
	allergies	
	weight loss/gain	
	confusion	
	blood sugar issues	
	prostate problems	
	cycle irregularities	
	discolored urine	
	irritable bowel	
	liver problems	
	paralysis	
	fatigue	
	cancer	
	trouble walking	

Past	Symptom	Present
	low back pain	
	arm/hand tingling	
	leg pain	
	abnormal BP	
	blurred vision	
	poor appetite	
	fainting	
	depression	
	nausea	
	breast pain/lump	
	painful urination	
	heartburn	
	bloody stools	
	leg/foot numbness	
	loss of sleep	
	ear pain	
	leg cramps	
	substance abuse	

Past	Symptom	Present
	migraines	
	jaw pain/clicking	
	heart problems	
	ankle swelling	
	sinus issues	
	excessive appetite	
	uncontrolled anxiety	
	excessive thirst	
	vomiting	
	menstrual cramps	
	frequent urination	
	gas/bloating	
	constipation	
	stroke	
	mid back pain	
	hearing loss	
	hip pain	
	hemorrhoids	

CURRENT CONDITION

Reason for your visit today? Wellness/Maintenance OTHER Specify:

How long has this bothered you? _____ Days _____ Months _____Years

Have you ever seen a chiropractor before? YES NO — **How long ago?** **If yes, was it for this condition?** YES NO

Have you seen anyone else for this ? YES NO — **Who?**

Was the outcome helpful? YES NO UNSURE — **When was your last visit?**

What else have you done for this?

What makes your situation better? — **What make your situation worse?**

On a scale of 0-10 (0=no pain 10= most pain) How would you rate your pain?

Please mark the diagram with the location(s) of your health concern:
Is there anything else we should know?