Kehoe Family Chiropractic
7212 Massachusetts Ave.
New Port Richey, FL 34653
727-859-9700
www.kehoechiro.com

We are honored to serve you today.
Our new patient forms help us
determine if chiropractic can help you.
We only accept those patients
that we can help.

Welcome to Our Office

NEW PATIENT

Name_____ **Preferred Name** _____

Address _____
City **State** **Zip**

Date of Birth_____ **Email address:**_____

Home Phone_____ **Cell Phone**_____

Which number would you like to us to call, if we need to contact you? ❍ HOME or ❍ CELL

Occupation:_____**Employer**_____

How do you spend most of your work day? ❍ Sitting ❍ Walking ❍ Standing ❍ Laboring Other _____

Marital Status ❍ married ❍ separated ❍ divorced ❍ widowed ❍ single ❍ engaged
Emergency Contact Name/Relationship & #_____

Check all that apply: ❍ Drink Coffee _____**❍ Drink Tea**_____**❍ Smoke** _____
(specify type/amounts) ❍ Drink Alcohol _____ **❍ Artificial Sweeteners** _____
❍ Soft Drinks_____ **❍ Recreational Drugs** _____
How much water do you typically drink in a day? _____
Please List:

	Medications	**For What Condition**	**Taken How Long**
Please list all meds. OTC & Prescribed	**1.**		
	2.		
	3.		

	Vitamins/Supplements/Herbs	**For What Condition**	**Taken How Long**
	1.		
	2.		
	3.		

Have you recently been vaccinated? ❍ yes ❍ no If yes, for what? _____

How would you best describe your diet? ❍ poor ❍ fair ❍ adequate ❍ good ❍ excellent
How many servings of different fruits/vegetable do you eat per day? _____
Are you on a special diet? (example: vegetarian, no dairy) _____

Have you seen a Chiropractor before? ❍ yes ❍ no If yes, who?
Chiropractor _____ **City**_____ **Last seen?** _____
For what reason? _____

List medical doctor(s) you have seen within the past year:

1. Name _____ **City** _____**Last seen?** _____
Reason for visit _____

2. Name _____ **City** _____ **Last seen?** _____
Reason for visit _____

List ALL Surgeries/Hospitalization:

Type _____ **Date** _____

Past Accidents/Injuries/Stitches/Broken Bones

Type _____ **Date** _____

Type _____ **Date** _____

CURRENT CONDITION

REASON FOR YOUR VISIT TODAY: _____

***If this visit is for general wellness/spinal maintenance please skip to next section.**

HOW LONG HAS IT BOTHERED YOU? ❍Days ❍Weeks ❍Months ❍Years

Have you seen anyone else for this so far? ❍ Yes ❍ No

If Yes, who? Name and type of practitioner. _____

What have you done so far for this situation? _____

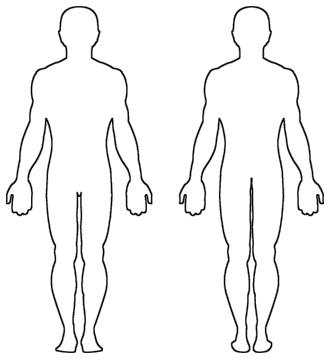
What makes your situation better? _____

What makes your situation worse? _____

On a scale of 1-10 (1= least pain 10= most pain)

How would you rate your situation? _____

Please specify on the diagram, the location of your pain or discomfort.



FRONT BACK

Health History

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

Past	Symptom	Present
❍	neck pain	❍
❍	headache	❍
❍	arm/hand tingling	❍
❍	leg pain	❍
❍	chest pain	❍
❍	heart problems	❍
❍	swelling in ankles	❍
❍	blurred vision	❍
❍	allergies	❍
❍	unexplained weight loss	❍
❍	excessive appetite	❍
❍	confusion	❍
❍	dental problems	❍
❍	nausea	❍
❍	prostate problems	❍
❍	menstrual cramps/irregularity	❍
❍	bladder troubles	❍
❍	gas/bloating	❍
❍	irritable bowel	❍
❍	constipation	❍
❍	liver problems	❍
❍	stroke	❍
❍	fatigue	❍
❍	difficulty hearing	❍
❍	mid back pain	❍
❍	cancer	❍
❍	hip pain	❍

Past	Symptom	Present
❍	low back pain	❍
❍	migraines	❍
❍	shoulder pain	❍
❍	jaw pain	❍
❍	breathing difficulties	❍
❍	abnormal blood pressure	❍
❍	cold extremities	❍
❍	stuffy nose/sinuses	❍
❍	fainting	❍
❍	poor appetite	❍
❍	nervousness	❍
❍	depression	❍
❍	excessive thirst	❍
❍	vomiting	❍
❍	breast pain/lumps	❍
❍	painful urination	❍
❍	discolored urine	❍
❍	heartburn	❍
❍	bloody stools	❍
❍	hemorrhoids	❍
❍	leg/foot numbness	❍
❍	paralysis	❍
❍	loss of sleep	❍
❍	ear pain	❍
❍	alcohol/substance abuse	❍
❍	leg cramps	❍
❍	Other _____	❍