

**Kehoe Family Chiropractic LLC**  
7212 Massachusetts Ave.  
New Port Richey, FL 34653  
727-859-9700

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 and want to be helped.**



## NEW PATIENT

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Is it okay to contact you at work?  yes  no Work Phone \_\_\_\_\_

Email address: \_\_\_\_\_

SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

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 \_\_\_\_\_

Please List:

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

	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? \_\_\_\_\_

Have you seen a Chiropractor before?  yes  no If yes, who?

Chiropractor \_\_\_\_\_ City \_\_\_\_\_ Last seen? \_\_\_\_\_

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

Type \_\_\_\_\_ Date \_\_\_\_\_

Type \_\_\_\_\_ Date \_\_\_\_\_

**REASON FOR YOUR VISIT:** \_\_\_\_\_

**HOW LONG HAS IT BOTHERED YOU:** \_\_\_\_\_ Days Weeks Months Years

What makes your situation better? \_\_\_\_\_

What makes your situation worse? \_\_\_\_\_

### 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	Past	Symptom	Present
<input type="radio"/>	neck pain	<input type="radio"/>	<input type="radio"/>	low back pain	<input type="radio"/>
<input type="radio"/>	headache	<input type="radio"/>	<input type="radio"/>	migraines	<input type="radio"/>
<input type="radio"/>	arm/hand tingling	<input type="radio"/>	<input type="radio"/>	shoulder pain	<input type="radio"/>
<input type="radio"/>	leg pain	<input type="radio"/>	<input type="radio"/>	jaw pain	<input type="radio"/>
<input type="radio"/>	chest pain	<input type="radio"/>	<input type="radio"/>	breathing difficulties	<input type="radio"/>
<input type="radio"/>	heart problems	<input type="radio"/>	<input type="radio"/>	abnormal blood pressure	<input type="radio"/>
<input type="radio"/>	swelling in ankles	<input type="radio"/>	<input type="radio"/>	cold extremities	<input type="radio"/>
<input type="radio"/>	blurred vision	<input type="radio"/>	<input type="radio"/>	stuffy nose	<input type="radio"/>
<input type="radio"/>	allergies	<input type="radio"/>	<input type="radio"/>	fainting	<input type="radio"/>
<input type="radio"/>	unexplained weight loss	<input type="radio"/>	<input type="radio"/>	poor appetite	<input type="radio"/>
<input type="radio"/>	excessive appetite	<input type="radio"/>	<input type="radio"/>	nervousness	<input type="radio"/>
<input type="radio"/>	confusion	<input type="radio"/>	<input type="radio"/>	depression	<input type="radio"/>
<input type="radio"/>	dental problems	<input type="radio"/>	<input type="radio"/>	excessive thirst	<input type="radio"/>
<input type="radio"/>	nausea	<input type="radio"/>	<input type="radio"/>	vomiting	<input type="radio"/>
<input type="radio"/>	prostate problems	<input type="radio"/>	<input type="radio"/>	breast pain/lumps	<input type="radio"/>
<input type="radio"/>	cramps	<input type="radio"/>	<input type="radio"/>	painful urination	<input type="radio"/>
<input type="radio"/>	bladder troubles	<input type="radio"/>	<input type="radio"/>	discolored urine	<input type="radio"/>
<input type="radio"/>	gas/bloating	<input type="radio"/>	<input type="radio"/>	heartburn	<input type="radio"/>
<input type="radio"/>	irritable bowel	<input type="radio"/>	<input type="radio"/>	bloody stools	<input type="radio"/>
<input type="radio"/>	constipation	<input type="radio"/>	<input type="radio"/>	hemorrhoids	<input type="radio"/>
<input type="radio"/>	liver problems	<input type="radio"/>	<input type="radio"/>	stroke	<input type="radio"/>
<input type="radio"/>	stroke	<input type="radio"/>	<input type="radio"/>	paralysis	<input type="radio"/>
<input type="radio"/>	fatigue	<input type="radio"/>	<input type="radio"/>	loss of sleep	<input type="radio"/>
<input type="radio"/>	difficulty hearing	<input type="radio"/>	<input type="radio"/>	ear pain	<input type="radio"/>
<input type="radio"/>	mid back pain	<input type="radio"/>	<input type="radio"/>	Other _____	<input type="radio"/>

### OUR COMMITMENT TO YOU!

As our commitment to your wellness and EXTRAordinary service to you, we would be honored to submit a written copy of your findings to your primary care physician and/or other health care professional. We will also provide a copy to you. Please simply supply us with your other doctors' names and city of practice and we will do the rest.

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