LIVE YOUNG

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____

(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Marital status: _____ # of Children: _____ Occupation: _____

Social Security #_____-_____-_____

Can Dr. Kennedy use your email address to contact you concerning your care? ☐ Y/ ☐ N

How did you hear about this clinic: ☐ Walk by ☐ Website ☐ Flyer

☐ Referral: _____ ☐ Newspap ☐ Other: _____

Name of Medical Doctor: _____ Permission to contact ☐ Y/ ☐ N

MAIN HEALTH CONCERNS

My usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What brings you in today?

_____

FAMILY & PERSONAL HISTORY

Please list family members (or yourself) who have the following conditions:

Cancer:	Autoimmune disease:
Eczema:	Arthritis:
Diabetes:	Allergies:
Heart disease:	Asthma:
High blood pressure:	Addictions:
Stroke:	Liver disease:
Thyroid disease:	Mental illness:

List major childhood illnesses: (ear infections, strep throat, tonsillitis, chicken pox, measles, etc.)

_____

In order to gain an appreciation for your current health situation, please answer the following questions to the best of your knowledge:

1. Have you ever been treated by a chiropractor before? If yes, what treatments did you receive?

☐ Adjustments ☐ Electrical Stim ☐ Laser ☐ Soft Tissue Therapy

2. Tell me about what brings you in:

Area of complaint/ pain / concern:

How did it happen:

Has this ever happened to you before:

When did this first start:

Was it gradual or sudden:

Have you found anything that is helpful:

What provokes or makes it worse:

How would you describe the pain:

☐ Sharp ☐ Dull ☐ Ache ☐ Throbbing ☐ Stabbing

Does the pain / symptom stay local or radiate:

How bad, on a 1-10 scale, is it bothering you:

Are there any times during the day that are better:

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Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description: _____

Year: _____ Description: _____

List any allergies that you know of:

_____

Please list all medications you are currently taking:

1._____ 4. _____

2. _____ 5._____

3. _____6._____

Please list supplements you are currently taking:

1. _____ 4. _____

Height _____ Weight _____

Informed Consent and Request for Chiropractic Care

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Kennedy will discuss the potential benefits, risks and hazards involved. After signing this consent form, I understand I can withdraw consent at any time.

I recognize that even the gentlest therapies may potentially have complications in very young children, the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and medications, including over-the-counter medications, supplements, and herbs.

Regarding health insurance patients: We will verify coverage with your insurance carrier to the best of our ability in order to provide you the best access to your benefits, however; in the event that your insurance carrier does not reimburse us for service, you hereby agree that you are liable for all costs incurred associated with your treatment. **If your health insurance does not pay your bill, you will be responsible for all visits at our self pay rates.**

I give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_____
Printed Name

_____
Signature

_____
Date