familychiropractic of Kennebunk

44 York Street, Kennebunk, Maine 04043
(207) 985-8877

Welcome to Our Office!

Our goal is to help you achieve better health. Please fill out the information below **completely** so that we may serve you to the best of our ability.

Name:_____ Preferred Name:_____

Address:_____

Street City State Zip

Phone Number(s)_____/_____/_____

Home Cell E-mail E- Newsletter Y N

Birth date:___/___/_____ Marital Status: S M D W Spouse's Name:_____

Do you have any kids? Y/ N Names & Ages:_____

Who can we thank for referring you?_____

Employer:_____ Work Phone:_____

Brief job description:_____

Have you ever been to a chiropractor? Y N Last adjustment:_____

Are you here for a specific problem or wellness? Please Explain;_____

_____

_____

What do you expect to gain from chiropractic care?

_____

Are you most interested in: _____ Correction of the Problem _____ Relief Only

On a scale from 1-10. 10 being the most important, how important is your health to you?

1 2 3 4 5 6 7 8 9 10

Do you know that irritation of spinal nerves can cause the body to malfunction? Y N

Do you smoke? Y N **Do you feel you eat properly?** Y N **Do you sleep well at night?** Y N

Please continue on other side

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Health History

Do you have, or have you had any of the following (please check all that apply)

☐ pneumonia ☐ heart disease ☐ diabetes ☐ arthritis

☐ polio ☐ thyroid disease ☐ epilepsy ☐ cancer

☐ depression ☐ eczema

If you have ever been diagnosed with another disease or condition, please describe:_____

_____

_____

Do you use ☐ coffee ☐ tea ☐ artificial sweeteners ☐ sugar

☐ alcohol ☐ cigarettes ☐ recreational drugs

Have you ever suffered from (please check all that apply for current and past conditions)

Current	Past		Current	Past		Current	Past	
☐	☐	neck pain	☐	☐	stuffy nose	☐	☐	discolored urine
☐	☐	low back pain	☐	☐	allergies	☐	☐	gas/bloating after meals
☐	☐	headache/migraine	☐	☐	fainting	☐	☐	heartburn
☐	☐	vision problems	☐	☐	weight loss	☐	☐	colitis
☐	☐	ear pain/infections	☐	☐	poor appetite	☐	☐	irritable bowel
☐	☐	shoulder/arm pain	☐	☐	excessive appetite	☐	☐	black/bloody stool
☐	☐	hand pain/tingling	☐	☐	nervousness	☐	☐	constipation
☐	☐	leg pain/tingling	☐	☐	confusion	☐	☐	hemorrhoids
☐	☐	jaw pain	☐	☐	depression	☐	☐	liver problems
☐	☐	chest pain	☐	☐	dental problems	☐	☐	stroke
☐	☐	lung problems	☐	☐	excessive thirst	☐	☐	paralysis
☐	☐	heart problems	☐	☐	frequent nausea	☐	☐	tingling
☐	☐	abnormal BP	☐	☐	vomiting	☐	☐	numbness
☐	☐	difficulty breathing	☐	☐	prostate problem	☐	☐	fatigue
☐	☐	ankle swelling	☐	☐	breast pain/lump	☐	☐	dizziness
☐	☐	cold extremities	☐	☐	cramps	☐	☐	irregular menses
☐	☐	blurred vision	☐	☐	difficulty hearing	☐	☐	loss of sleep

Past injuries can affect present health (please check all that apply)

☐ falls/accidents ☐ head injuries ☐ fights ☐ extensive dental work

☐ sports injuries ☐ broken bones ☐ traction ☐ knocked unconscious

☐ surgery ☐ spinal tap ☐ dislocations ☐ use (d) cane or walker

If yes to above, please describe: _____

_____

_____

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable.

Patient's Signature:_____