Kenyon Chiropractic **Arnold Kenyon D.C.**

Patient Name: _____Act#_____Date: _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor: _____

1. Past Health History:

A. Surgeries: ____ Appendix Removed ____ Bypass Surgery ____ Joint Surgery/Replacement
____ Cancer ____ Spinal Surgery ____ Tonsillectomy ____ Hysterectomy ____ Stints/Heart
____ Pins/Appliances/Devices/Implants/Fusion. List: _____

B. Previous Injury or Trauma: ____ Motor Vehicle Accidents (Even if it was years ago)
____ Falls ____ Fall off a horse____ Sports Injury (include childhood injuries) _____
____ Exercise Injury ____ Forceps delivery at birth ____ Landed on tailbone ____ Contact sports

C. Have you ever broken any bones? Yes____ No____ Which _____
____ Compression fracture of the spine? ____ Neck ____ Mid back ____ Low back
____ Been diagnosed with Osteoporosis or been treated for it? _____

D. Any of the following symptoms? ____ Double vision, ____ Vertigo, light headedness
____ Sudden numbness/weakness of the face/arm/leg ____ Speech disorders ____
____ Difficulty swallowing ____ Difficulty walking ____ Nausea, queasy stomach
____ Loss of sensation, numbness on one side ____ Involuntary rapid eye movements
____ Sudden onset of headache/neck/face pain that is different than you've had before ___None

E. Illnesses: ____ AIDS ____Alcoholism **____** Allergies ____ Arteriosclerosis ____ Cancer
____ Diabetes ____ Epilepsy ____ Glaucoma ____ Goiter ____ Gout ____ Heart disease
____ Hepatitis ____ HIV Positive ____ Malaria ____ Measles ____ Multiple Sclerosis
____ Polio ____ Rheumatic fever ____ Scarlet fever ____ Sexually transmitted disease
____ Stroke ____ Tuberculosis ____ Typhoid fever ____ Ulcer ____ Arthritis ____ None
____ Other _____

2. Family Health History:

Do you have a family history of? (Please indicate all that apply)
□ Cancer □ Strokes/TIA's □ Headaches □ Heart disease □ Neurological diseases
□ Adopted/Unknown □ Cardiac disease below age 40 □ Psychiatric disease
□ Diabetes □ Other _____ □ None of the above

Relative	**Age (If living)**	**Illnesses**	**Age and cause of death**
Mother	_____	_____	_____
Father	_____	_____	_____
Sibling	_____	_____	_____

2003 West Owen K Garroitt **580.237.2289**

3. Medications:

Allergies to any medications? Yes__No__ If yes, please list. _____
Medication/Reaction to med's_____

Are you taking any medications? Yes__No__ Reason for taking
_____
_____
_____
_____
_____

Long term use of: ____ Steroids ____ Antibiotics

4. Social History:

Water Intake ____ Daily ____ Weekly How much?_____
Coffee Intake ____ Daily ____ Weekly How much? _____
Tobacco Use ____ Daily ____ Weekly How much?_____
Exercise ____ Daily ____ Weekly How much?_____
Soft Drinks ____ Daily ____ Weekly How much?_____
Alcohol Use ____ Daily ____ Weekly How much?_____

Does your current condition interfere with your ability to function? Yes___No___

____ Sitting ____ Rising out of a chair ____ Standing ____ Walking ____ Lying down
____ Sleeping ____ Staying asleep ____ Getting to sleep ____ Bending over ____ Climbing stairs
____ Using a computer ____ Getting in/out of a car ____ Driving a car ____ Lifting objects
____ Reaching overhead ____ Putting on socks/shoes ____ Exercising ____ Yard work/gardening
____ Sitting on the floor ____ Rising from the floor ____ Cleaning house ____ Grocery shopping

5. Previous Diagnosis: ____ Aortic aneurysm ____ Disc bulge/herniation/slipped ____ Pinched nerve
____ Spondylolisthesis (forward slipping of a vertebrae) ____ Multiple Myeloma ____ Bone tumors
____ Osteomyelitis ____ Paget's disease ____ Ankylosing Spondylitis ____ Rheumatoid arthritis
____ Psoriatic arthritis ____ Reactive arthritis (Reiter's syndrome) ____ Joint or bone infection ____None

Review of Systems

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery
□ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____
□ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections
□ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation
□ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools
□ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use
□ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia
□ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Kenyon Chiropractic for services performed.

Patient or Guardian Signature _____
Date_____

NEW PATIENT HISTORY FORM

Symptom/Complaint: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin: ____ suddenly ____ gradually?
- When did the symptom begin? ____ Days ____ Weeks ____ Months _____
    - What do you think caused it? _____

- What makes the symptom worse? (circle all that apply):
    - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _____

- What makes the symptom better? (circle all that apply):
    - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _____

- Describe the quality of the symptom (circle all that apply):
    - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging Other (please describe): _____

- Does the symptom radiate to another part of your body: yes no
    - If yes, where does the symptom radiate? _____

- Is the symptom worse at certain times of the day or night? (please circle)
    - No difference Morning Afternoon Evening Night Other _____

- Have you received treatment for this condition and episode prior to today's visit?
    - No
    - Anti-inflammatory meds
    - Pain medication
    - Muscle relaxers
    - Trigger point injections
    - Cortisone injections
    - Surgery
    - Massage
    - Physical Therapy
    - Chiropractic