



Matrix Repatterning Patient Entrance Form
Dr Enid Kennedy, DC

Name: _____

Birthdate: _____

Address: _____

Phone number: _____ **Email:** _____
(number you prefer to be reached at)

How did you hear about us: _____

Emergency Contact - Name: _____

Emergency Contact - Number: _____

Medical Doctor:

Name: _____

Phone: _____

Address: _____

Previous chiropractic care: **Yes** **No**

Previous therapies: (please list) _____

Were you referred to us: **Yes** **No**

If so, by whom? _____

(please note, we only ask so that we are able to thank them for their referral. Word-of-mouth referral is the main way I build my practice and I very much appreciate any referrals I receive!)

MIRANDA NATUROPATHIC CLINIC
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PATIENT HEALTH HISTORY

Patient Name: _____

Date: _____

Trauma:

Motor Vehicle Collisions: _____

Date: _____

Injuries sustained: _____

Date: _____

Injuries: _____

Surgery/hospitalizations: _____

Falls/Accidents: _____

Fractures/Sprains: _____

Head injuries/concussions: _____

Allergies: (medications or other) _____

Dental Work: (root canals, extractions, fillings, other) _____

Medications: (presently taking and for what)

Digestive: (constipation, diarrhea, ulcers, food sensitivities, irritable bowel, acid reflux, or other)

Patient Name: _____

Date: _____

Cardiovascular: (heart conditions)

Blood pressure: normal high low

Cholesterol: normal high

History of stroke or heart attack: yes no

Family history: _____

Women: (menstrual pain, dysfunction, endometriosis, hysterectomy, cysts, hormonal imbalance)

Pregnancy: yes no **How many:**

Complications: _____

Men: (prostate, pelvic pain, other) _____

Headaches: (migraines, tension-type, jaw/TMJ) _____

Sleep Disorders: _____

Ear/Eye/Nose/Throat: (tinnitus, pain, sinus infections, other)

Significant Stress: _____

Decreased Energy: yes no

Frequent Colds: yes no

Thyroid Imbalance: yes no

Family Medical History Conditions: _____

Other: (anything not addressed above)
