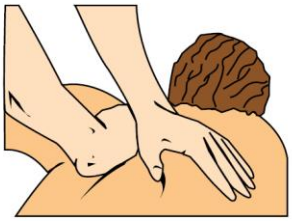


Dr. Enid Kennedy
905-239-3900

Chiropractic Intake Form

Name_____ Date _____
Address _____
City, Province _____ Postal Code _____
Home Tel _____ Bus Tel _____ Cell _____
E-mail _____ Gender M____ F_____
Date of Birth (D/M/Y) _____ Age _____ Marital Status S M D W S
Spouse's Name _____ Children _____
Occupation (Your) _____
Employer _____ Address _____
Closest Relative _____ Phone _____

Were you referred to to Dr. Kennedy? _____ Dr. Kelly? _____ No Referral?_____

CLAIM WILL BE MADE AGAINST:

1. Recent motor vehicle accident: Yes No (if Yes, see attached)
2. Work related injury/accident Yes No (if Yes, see attached)

PRIOR CHIROPRACTIC CARE:

Name _____ Phone _____
X-rays taken: YES NO Date:_____
Results: Excellent Good Fair Poor

MEDICAL DOCTOR:

Name:_____ Telephone:_____
Address:_____
Date of Last Appointment _____ Date of Last Physical:_____

Reason for consulting this office: _____

_____

_____

Expectations: _____

Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas radiation. Include all affected areas.

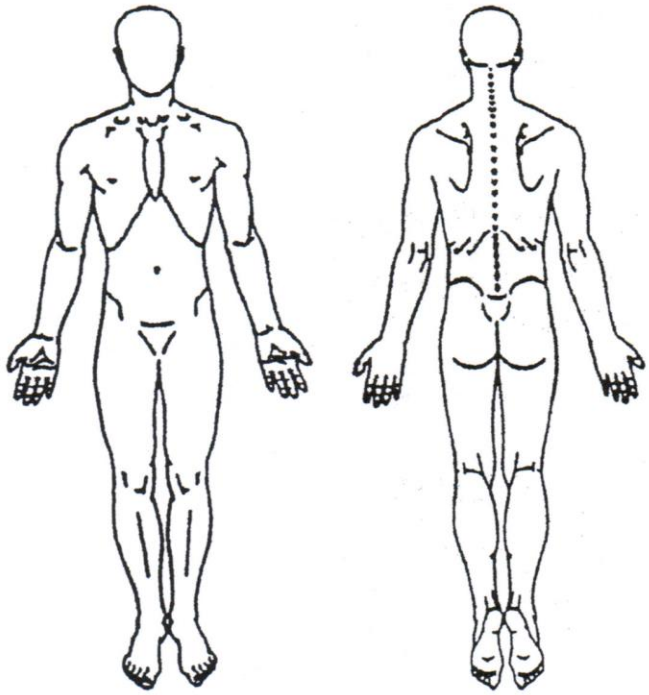
Numbness • • • • •
• • • • •
• • • • •

Pins & Needles 0 0 0 0 0
0 0 0 0 0
0 0 0 0 0

Burning XXXXX
XXXXX
XXXXX

Aching * * * * *
* * * * *
* * * * *

Stabbing / / / / /
/ / / / /
/ / / / /



Have you ever had any of the following:

aneurysm _____ ostheoporosis _____ diabetes _____ arthritis _____

respiratory conditions _____ epilepsy _____ cancer _____

strokes _____ allergies _____ heart conditions _____

hepatitis _____ nerves _____ fatigue _____ polio _____

sleeping difficulty _____ pneumonia _____ pleurisy _____

asthma _____ V.D. _____ psoriasis _____ HIV _____

sinus conditions _____

Childhood conditions had, please check:

- ☐ measles
- ☐ mumps
- ☐ chicken pox
- ☐ whooping cough
- ☐ scarlet fever
- ☐ diphtheria
- ☐ rheumatic fever
- ☐ typhoid fever
- ☐ ear infections
- ☐ tubes in ears
- ☐ chronic ill

Side 2