Deep Wellness CHIROPRACTIC

"I, the undersigned, grant permission for Dr. Frederick Kennedy, Chiropractor, to perform chiropractic exams, adjustments, and/or myofascial trigger point therapy in accordance with his findings and recommendations. I understand that Dr. Kennedy does not diagnose or treat any specific condition and that all services are rendered for the purpose of *improved function*. I agree to pay in full for all services rendered at the time of service.

Signed: _____

Today's Date: _____

Preferred Name: _____

Last Name: _____

Cell Phone: _____

Email: _____

_____

Date of Birth: _____ Age: _____

Referred By: _____

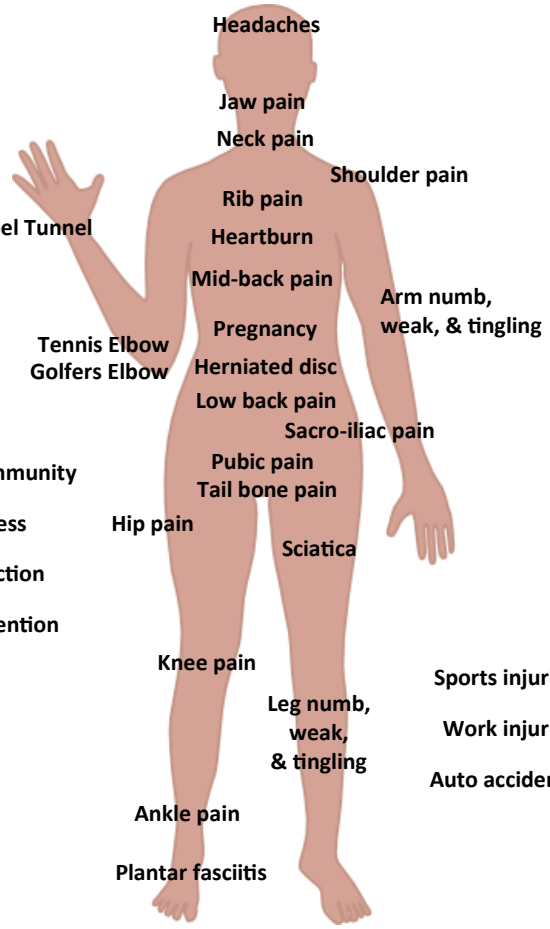
_____

Health Goals: ☐ Pain relief

☐ Pain relief and long-term correction

☐ Wellness care

Please circle ALL the concerns that you have below:



Suppressed immunity

General stiffness

Posture correction

Scoliosis prevention

Arthritis

Fibromyalgia

Wellness

Sports injuries

Work injuries

Auto accidents

What is your ***primary*** concern?_____

_____

Where in or on your body do you find it?_____

_____

When did it start?_____

Have you had it before? **YES** **NO** When:_____

What does it feel like? **SHARP** **DULL** **SORE** **RADIATES** **AT NIGHT** **INTERMITTANT** **WITH M0VING** _____

Is it getting better or worse? **BETTER** **WORSE**

What movement or activity makes it worse?_____

_____

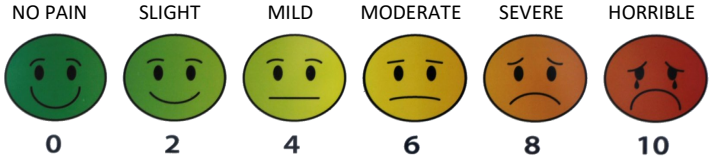
What makes it feel better? **ICE** **HEAT** **REST** **MASSAGE** **EXERCISE** **MEDICATION** _____

Does it radiate to other places in your body? **SHOULDERS** **ELBOWS** **HANDS** **HIPS** **KNEES** **FEET** **JAW** **HEAD** **NECK** **CHEST** **RIBS**

Have you seen other practitioners for this concern? **YES** **NO**

If so, who?_____

On the pain scale, how bad is the concern right now? (Please circle.)



Do you have any bone fractures? **YES** **NO**

Do you have any form of cancer? **YES** **NO**

Do you take blood thinners? **YES** **NO**

Please list all other health concerns you have:_____

_____

_____