Dr. Jud Kendall D.C.
Dr. Pam Kendall D.C.
190 S. Peytonville, Suite 120
Southlake, TX 76092
Office: 817.488.6888
Fax: 817.946.5888
Web: www.kendallcare.com

Confidential Patient Information

Name:_____
(first) (middle) (last)

Address:_____City/St._____Zip:_____

Telephone: _____ _____ _____
(home) (work) (cell)

Email:_____

Age:_____ Birthday:_____ Social Security Number:_____

Employer:_____ Occupation:_____

Marital Status: M S W D Name of Spouse (if applicable): _____

Children; names/ages_____

How did you hear about our office? _____

Patient History:

Prior Chiro/Acu Experience; date, reason for leaving:_____

Date of last Physical:_____ Doctor Name:_____

Main Complaint and purpose of this visit:_____

How long has this problem existed?_____ How did it start? _____

What have you done for this problem that hasn't worked?_____

What helps?_____

How does this limit your daily activities? _____

What makes the problem worse for you?_____

Is the problem? _____constant _____occasional _____intermittent _____cyclic

Have you been evaluated for this or any other health conditions? (circle) yes no
Treatment Provided for other conditions:_____
Have you had any diagnostic tests? (circle) Xray MRI NCV/EMG CT Other:_____
Surgical History/Date:_____
_____
ALL Current Medications: (Rx or OTC) _____
_____

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Circle all that apply:

Exercise: Never Occasional 3-5x/week Daily
Alcohol: Never 2-5x/week Daily
Sleep: Hrs/night_____

Tobacco: Never Occ. Light Med Heavy
Caffeine: Never Occ. Daily
Dominant Hand: Right or Left

Allergies:_____

History of Accidents:

Date/Age: Type of Accident: Injury Type:

_____

_____

Had any of the Following: _____Heart Trouble _____Cancer _____Diabetes _____Epilepsy _____Alcoholism _____Depression _____Insomnia _____Arthritis _____Dizziness

Please Circle All **Current** Symptoms:

+MUSCLE/JOINT/NECK
Spasms
Stiffness

+MID-BACK
Pain
Spasms
Weakness
Stiffness

+NUMBNESS
Arms L/R
Hands L/R
Legs L/R
Feet L/R

+Joint Swelling
+Spinal Curvature
+Tail=Bone Pain

+Other:_____
_____
_____
_____

+ LOW BACK
Pain
Spasms
Weakness
Stiffness

+PAIN
Arms/Shoulders L/R
Hands/Elbows L/R
Hips/Legs/Knees L/R
Feet/Ankles L/R

+ SKIN
Rashes Itching
Bruising Dryness
Slow Healing
Hives

+RESPIRATORY
Chronic Cough
Difficulty Breathing
Asthma
Emphysema

+GENERAL
Headaches
Dizziness
Fainting
Sleep Loss
Fatigue
Nervous
Frequent Colds
Sinus Infections

+CARDIOVASCULAR
Irregular heart
High Blood Pressure
Chest Pain
Ankle Swelling
Poor Circulation
Stroke
Varicose Veins
Anemia

+GASTROINTESTINAL
Poor Appetite Poor Digestion
Excess Hunger Belching Gas
Nausea Vomiting Diarrhea
Abdominal Bloating Constipation
Colon Trouble Hemorrhoids
Liver Trouble Gallbladder
Weight Loss Colitis Hiatal Hernia
Gluten Intolerance IBS

+GENITO-URINARY
Frequent Urination
Painful Urination
Kidney Stones
Kidney/Bladder Infections
Prostate

+WOMEN ONLY
PMS
Excessive Flow
Irregular Cycles
Yeast Infections
Breast Lumps
Menopause
Are you Pregnant? Y N

Women Only:

Last Menstrual Period:_____ Using Contraception:_____
Infertility concerns:_____
Suffer from PMS:_____ Have Severe Menstrual Cramps:_____
Hormonal Difficulty:_____ Peri/menopause symptoms:_____

Is there any more we should know? _____

Signature:_____Date:_____