



Joseph D. Kepo'o, D.C.

Today's Date: _____

Name: _____ SSN: _____

Address: _____ City: _____

State: _____ Zip code: _____ Date of Birth: _____ Age: _____

Married Single

Home Phone: _____ Occupation: _____

Work Phone: _____ Employer: _____

Cell Phone: _____ Employer Address: _____

E-mail: _____

Spouse's Name: _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Home(____) _____ Cell (____) _____

How did you hear about us? _____

Have you had previous healthcare for your present problem? Yes No

If yes, where? _____ When? _____

Your Doctor's name: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Doctor's phone number: _____ Diagnosis by your Doctor: _____

Reason for Consulting Our Office

What are your five main health concerns & how long have you had them?

1. _____
2. _____
3. _____
4. _____
5. _____

What activities aggravate your conditions? _____

What makes them better? _____

Are any of your conditions getting progressively worse? Yes No Constant

Comes and goes

Are your conditions interfering with: Work Sleep Daily Routine

Please describe:

(More on Back of Page)

List surgical operations and/or major surgeries with dates:

List any significant illnesses or injuries with dates:

List any prescription drugs, over the counter drugs, vitamins, and natural supplements that you are presently taking:

List any known allergies: _____

List all known physical abnormalities: _____

Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Support Orthotics

Have you ever been in an auto accident? No Recently Past Year

Past 5 years or more

Describe the accident: _____

Have you had another personal injury/accident: No Recently Past Year

Past 5 years or more Describe: _____

Date of most recent physical exam: _____

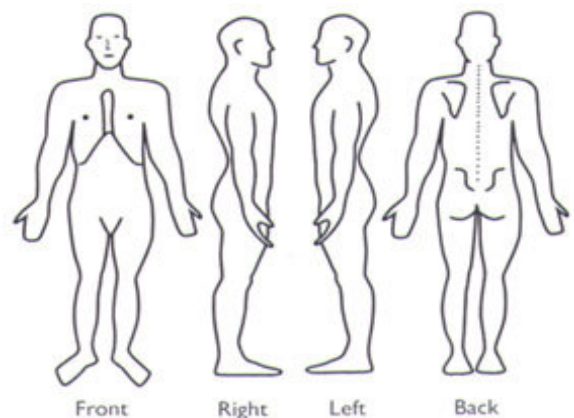
Please Mark the Areas of Pain and/or Discomfort on the Figures Below

Rate the severity of your pain on a scale from 0 to 10. (0 = None, 10 = Greatest) _____

Type of Pain:

- | | | |
|--------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Cramps | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Swelling | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | |
| <input type="checkbox"/> Other _____ | | |

How often do you have this pain? _____



(More Next Page)

Are you affected by any of the following?

Please check: **O** = Occasionally **F** = Frequently **C** = Constantly

	O	F	C		O	F	C		O	F	C				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hi Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restless Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Candida/Yeast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IBS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Females only:			
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hard to Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Painful menstruation			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> PMS			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OCD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parasites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No			

I, the undersigned, having been explained the risks of treatment, do hereby request and consent to the performance of **wellness care** and related procedures upon the above-named patient (my dependent or myself). I wish to rely on the doctor or practitioner to exercise judgment for my best interest during the course of treatment. I will inform the doctor or practitioner who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

We thank you for your patience and cooperation in completely filling out this form.
Patient's Signature: _____ Date: _____

I agree to the Privacy Practices for Ohana Chiropractic. I am aware that I am entitled to a copy.

Patient Signature: _____ Date: _____

For Office Use:

Cx ROM	P/D	
Flx 50°		
Ext 60°		
LLF 45°		
RLF 45°		
LR 80°		
RR 80°		

Cx Ortho	L	R
CC		
CD		
SD		
SH		

Lx ROM	P/D	
Flx 60°		
Ext 30°		
LLF 25°		
RLF 25°		
LR 13°		
RR 13°		

Lx Ortho	L	R
SLR		
BRG		
PAT		
KEMP		

ph test: _____

Stress test: High Mid Low

X-rays:

Cx: AP Lat
4VW Compete
Lx: AP Lat
Other:

Dx: 739.1 739.2 739.3
739.4 781.92 847.0
847.1 847.2 847.3
847.4 Other:

Tx Plan: CMT PNF
Mech. Tract Ther. Ex.
Ice 15/60 Heat
Man. Ther Other:

Subluxation Levels

_____ C1 _____	_____ T4 _____	_____ L2 _____
_____ C2 _____	_____ T5 _____	_____ L3 _____
_____ C3 _____	_____ T6 _____	_____ L4 _____
_____ C4 _____	_____ T7 _____	_____ L5 _____
_____ C5 _____	_____ T8 _____	_____ Sacrum _____
_____ C6 _____	_____ T9 _____	SL: L R X
_____ C7 _____	_____ T10 _____	Deerfield: L R
_____ T1 _____	_____ T11 _____	
_____ T2 _____	_____ T12 _____	
_____ T3 _____	_____ L1 _____	

Additional Notes: