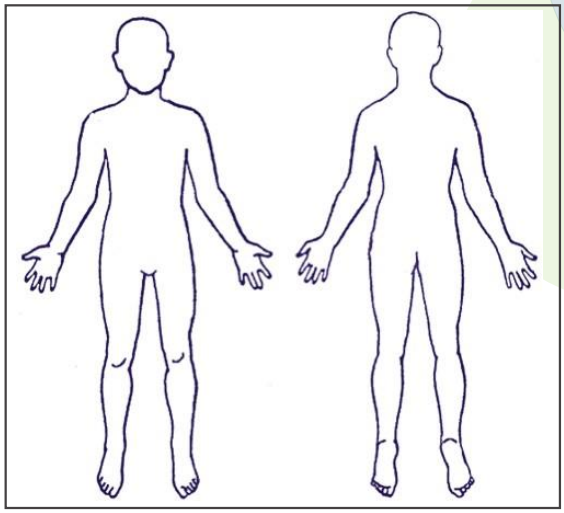
synergyhealth

Patient History

Please mark (x) on the diagram below where you are feeling pain.



Patient Name: _____

Date of Birth_____/_____/_____ **Height**

_____**Weight** _____

Referring Provider _____

CHIEF COMPLAINT:

What is bothering you? Which areas of your body are affected?

_____

_____

_____

QUALITY OF PAIN: Circle the quality of pain you have experienced on average for the past month:

INTENSITY: Excruciating Severe Moderate Mild Noticeable None

% of the Day: Occasional 0-25% Periodic 26-50% Frequent 51-75% Constant 76-100%

SENSATION: Piercing Stabbing Shooting Burning Throbbing Cramping
Aching Stinging Squeezing Numbing Tingling None

SEVERITY: Indicate the number that best describes your pain level: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

DURATION/TIMING/AGGRAVATING & ALLEVIATING FACTORS:

How long have you had your symptoms (in months and years)? _____

What caused the symptoms to start? _____

How often do you have your symptoms? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

What treatments have you tried to treat your symptoms: ☐Chiropractic ☐Medication ☐Injections ☐PT ☐Massage
☐ Acupuncture ☐Heat ☐Ice ☐Other _____

What medications have you tried to treat your symptoms? _____

INITIAL TREATMENT GOAL: What would you like to achieve from treatments? _____

What treatments are you interested in trying? ☐Chiropractic ☐Medication ☐Injections ☐PT ☐Massage ☐ Acupuncture

ALLERGIES (please include reaction)**:** _____

MEDICATIONS (Include all over-the-counter and supplements):

	Medication Name	Strength/How often		Medication Name	Strength/How often
1.	_____	_____	5.	_____	_____
2.	_____	_____	6.	_____	_____
3.	_____	_____	7.	_____	_____
4.	_____	_____	8.	_____	_____

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Patient History

Have you ever had previous chiropractic care? ☐Yes ☐No

Type of Adjustments preferred: Diversified (Popping Sound) Mobilization (noiseless)
Activator or Instrument Adjustment ☐Thompson Drop Other:_____

Therapies that have helped in the past: ☐Adjustment ☐Massage ☐Electric Stim ☐Medications ☐Injections ☐Acupuncture ☐Physical Therapy

Mattress Age:_____ Sleep Position: ☐Side ☐Back ☐Stomach ☐All

Activity: ☐Sedentary ☐Light ☐Active ☐Very ☐Active

REVIEW OF SYMPTOMS: *Have you experienced any of the following in the past month? Circle all that apply:*

CONSTITUTIONAL: *Weakness, Fatigue, Weight Loss/Gain, Chills, Night Sweats, Fevers*

HEENT: *Headaches, Eye Pain, Decreased Hearing, Earache, Changes in Vision, Changes in Speech, Nasal Discharge*

CARDIOVASCULAR: *Chest Pain, Palpitations, Chest Pressure, Swelling of Legs/Feet, Demand Pacemaker, Defibrillator*

RESPIRATORY: *Persistent Cough, Shortness of Breath, Difficulty Breathing, Wheezing, TB Infection/Exposure*

ABDOMINAL: *Reflux, Nausea, Vomiting, Abdominal Pain, Diarrhea, Constipation, Blood in Stool, Fecal Soiling*

GENITOURINARY: *Urinary Frequency, Urinary Urgency, Blood in Urine, Bladder Incontinence*

NEUROLOGIC: *Numbness, Tingling, Weakness, Dizziness, Imbalance, Difficulty Walking, Fainting, Unsteady Gait*

PSYCHIATRIC: *Depression, Anxiety, Insomnia*

INTEGUMENTARY: *Easy bleeding/Bruising, Lumps/Bumps, Non-Healing Wounds*

MUSCULOSKELETAL: *Limb pain, Muscle Aches, Muscle Spasm, Joint Swelling, Joint Pain, Neck Pain, Hand/ Wrist Pain, Elbow Pain, Shoulder Pain, Mid-Back Pain, Low-Back Pain, Hip Pain, Knee Pain, Ankle Pain, Foot Pain*

ENDOCRINE: *Heat, Intolerance, Cold Intolerance, Changes in Appetite, Changes in Thirst*

HEME/ LYMPH: *Easy Bruising, Easy Bleeding, Swollen Glands*

ALLERGIC/ IMMUNE: *Autoimmune Disease, Communicable Disease*

MEDICAL HISTORY *Check box if you have a personal history of any of the following:*

- ☐ Atrial Fibrillation
- ☐ Asthma
- ☐ Allergies
- ☐ Anemia
- ☐ Bleeding
- ☐ Breast Cancer
- ☐ Bladder Cancer
- ☐ BPH
- ☐ Inflammatory Bowel Disorder
- ☐ Colon Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ DVT
- ☐ Drug/ Alcohol Abuse
- ☐ Epilepsy
- ☐ Gout
- ☐ Glaucoma
- ☐ GERD
- ☐ Gastric Ulcers
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Heart Disease
- ☐ Fibromyalgia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Leukemia
- ☐ Lupus
- ☐ Macular Degeneration
- ☐ Nephrolithiasis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis/
- ☐ Osteopenia
- ☐ Prostate Cancer
- ☐ Polymyalgia Rheumatica PMR
- ☐ Parkinson's Disease
- ☐ Prior MI
- ☐ Peripheral Vascular Disease
- ☐ Renal Disorder
- ☐ Rhythm Disorder
- ☐ Rheumatoid Arthritis
- ☐ Skin Cancer
- ☐ Stroke
- ☐ Syphilis
- ☐ Seizure Disorder
- ☐ Thrombocytopenia
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Vitamin Deficiency
- ☐ Other: _____

MEDICAL HISTORY *Continued:*

Do you have a demand pacemaker, cardiac defibrillator or implantable stimulator? ☐Yes ☐No

If Yes, Please Explain_____

Have you had any diagnostic studies? ☐MRI ☐ Xray ☐CT Scan ☐ NCV ☐Diagnostic Ultrasound

If yes, please list area and date: _____

Past Surgical History: (Procedure and Date) _____

_____

_____

FAMILY HISTORY: Circle all that apply

Significant for: Diabetes; Cancer; Heart Disease; Unobtainable/Adopted

Maternal: (Alive; Deceased) Cause of death:_____

Paternal (Alive; Deceased) Cause of death:_____

Number of Siblings:_____Significant Medical Illnesses: _____

WOMEN: Are you currently pregnant or plan on becoming pregnant? ☐Yes ☐No

SOCIAL HISTORY:

Current or history of drug use? ☐Yes ☐No If yes, please explain: _____

Current or history of alcohol use? ☐Yes ☐No Drinks per day_____Year Quit _____

Current or history of tobacco use? ☐Yes ☐No Packs per Day_____Year Quit_____

Current or history of caffeine use? ☐Yes ☐No Drinks per day_____Year Quit _____

Present living situation? ☐Alone ☐With Spouse ☐With Children ☐With Parents ☐With Other: _____

Marital History: ☐Married ☐Divorced ☐Widowed ☐Single

EDUCATION: ☐Some H.S. ☐High School ☐Some College ☐College Graduate ☐Advanced Degree

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary healthcare services I may need.

Signature:_____

Date: _____

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Patient History

GENERAL INFORMATION

Patient: Last Name:_____First Name: _____

Address:_____

City, State and Zip Code: _____

Home Phone (_____)_____Cell Phone: (_____)_____ Work

Phone (_____)_____Email Address: _____

Out of State Address: _____

Date of Birth:_____/_____/_____Age:_____Social Security #:____-____-_____Sex: ☐Male ☐Female

Appointment reminders: ☐Email ☐Text ☐Business Card

Emergency Contact: _____

Emergency Contact Phone #: (_____)_____Relationship:_____

Whom may we thank for referring you to us? _____

Employment: ☐Full Time ☐Part Time ☐Retired ☐ Not Employed

Patient's Employer: _____

Address:_____

Phone Number: (_____)_____Occupation: _____

Will you be using insurance today? ☐Self Pay ☐Health Insurance ☐Other

:

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Membership #:_____Group #: _____

Secondary Insurance Company Name: _____

Membership #:_____Group # : _____

AUTO ACCIDENT/WORKERS' COMPENSATION ONLY

Insurance Company Name:_____Claim #: _____

Adjustor's Name:_____Phone Number: (_____)_____

Attorney's Name:_____Phone Number: (_____)_____

Preferred Language:_____ ☐ Prefer not to say