SYNERGY
SPORT & SPINE®

Intake Form

Name _____ Date_____

Address _____City _____

State_____ Zip_____ Email _____

Phone_____ Date of Birth _____ Age:_____

Sex: M F Marital Status: S M D W

Employer _____

Occupation_____

Emergency Contact: Name _____Phone_____

Relationship to patient_____

How did you hear about us?_____

Present condition due to an injury? ___Yes ____No ____On the Job _____ Auto Accident ____

Other _____

Has the accident been reported? ____Yes ____No ___To Employer _____Auto Carrier _____

Other _____

Name:_____

Reason for seeking care:

_____

List any other doctors seen for this:

_____

List any diagnosis and type of treatment:

_____

Have you had similar accidents or injuries before? __ Yes __ No
If yes, explain: _____
Have you or any relative received chiropractic treatment previously? __ Yes __ No
If yes, explain: _____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain: _____
Have you been diagnosed with osteopenia or osteoporosis? __ Yes __ No if so, when? _____
Are you currently taking medication? __ Yes __ No list medications:

_____

List conditions you are taking medications for:

_____

List the approximate dates of any surgery or treated conditions:_____

Family Medical History

Father:

_____

Mother:

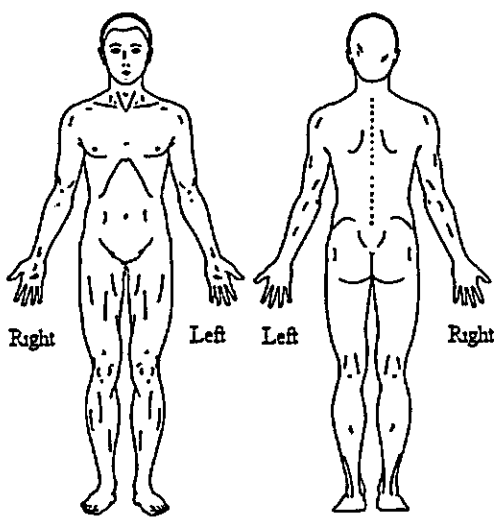
_____

Brother/s & Sister/s:

_____

Do you take Vitamins/Supplements Y/N If yes, type and how often

_____



Please circle degree of pain, 0 none, 10 severe pain.
0 1 2 3 4 5 6 7 8 9 10

Please mark on the picture where you are feeling pain

What activities aggravate your condition/pain?

_____

What activities lessen your condition/pain?

_____

Is this condition worse during certain times of the day? Y/N
Is this condition interfering with · Work?_____
Sleep?_____Routine?_____
Is this condition progressively getting worse?_____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.
I agree to allow this office to examine me for further evaluation.

Patient
Signature_____ Date_____