Today's Date: _____
Referred By: _____

Syn Chiropractic, Inc.
Progressive Family Wellness Center
Confidential Chiropractic Questionnaire

Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Phone: (H) _____ (w) _____ (cell)_____

Address: _____ City: _____ State _____ Zip: _____

Email Address: _____

Marital Status: S M D W / Spouse's Name _____

Children □ No □ Yes ages: _____

Occupation: _____ Employer _____ Hours worked / week _____

Health Information:

What are your **current health problems, challenges, and or conditions** (major or minor)?

_____

_____

Once these problems have been resolved, what are your future **health goals**? _____

_____

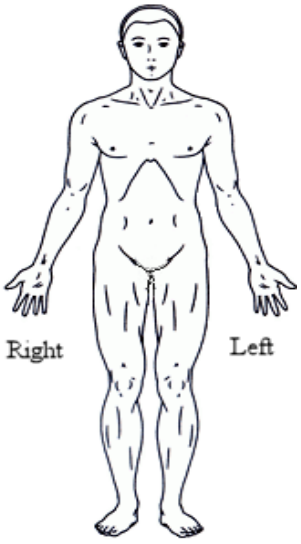
When did this/these problem(s) start and **how long** have you had this/them?

_____
_____
_____

Current Health

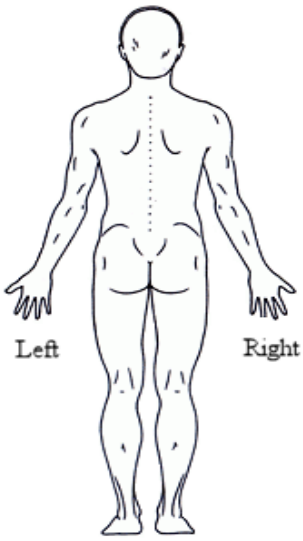
Is it ○ getting worse ○ improving ○ intermittent ○ constant ○ can't say

Where is the problem? Please use the illustrations and lines below to explain



○ Front _____
_____
_____
_____
_____

○ Back _____
_____
_____
_____
_____



Do You have: ○ pain ○ numbness ○ tingling ○ aches_____

Is your pain: ○ sharp ○ dull ○ throbbing ○constant ○ intermittent

Are your symptoms affected by:

○ sitting ○ standing ○ walking ○ bending ○ lying down ○ weather

Please explain: _____

Do you feel:

○ cramps ○ burning ○ other ○ swelling ○stiffness _____

Do your symptoms interfere with:

It interferes with (circle all that apply): work family sleep sex sports recreation

housework happiness ability to relax concentration other _____

On a scale of 1-10 (1 least, 10 most), please circle and rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Have you had previous care for this condition? □ No □ Yes

Is it getting worse? □ No □ Yes, How? _____

At its worst, how does it feel? _____

Do you want to get rid of this condition? □ Yes □ No

Have you had **previous Chiropractic Care**? □ Yes □ No This year? □ Yes □ No

Were you ever put on a **Spinal correction and stabilization program**? □ Yes □ No

Which doctor did you complete the program with? _____

Who was the last doctor who created a **health development plan** for you if any? _____

Did you follow all of the Doctor's recommendations? □ Yes □ No □ I was never put on a health plan

How long were you able to stay on the health development plan? _____

What were the results if any? _____

What other wellness professionals are currently a part of your health care team?

□ Massage Therapist □ Acupuncturist □ Naturopath □ Homeopath □ Other _____

How many Medical Doctor's office visits did you and your family have last year?
□ None □ Less than 5 □ More than 5 □ More than 10

Past Health History:

Please check all of the following health concerns you have experienced, even if you do not think that your answers relate to your present health concern.

Allergies	□ Yes	□ No	Heart Condition:	□ Yes	□ No
Anxiety	□ Yes	□ No	Immune System Disorder	□ Yes	□ No
Asthma	□ Yes	□ No	Infertility	□ Yes	□ No
Arthritis	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Back Pain	□ Yes	□ No	Menstrual Cramps	□ Yes	□ No
Bladder Problems	□ Yes	□ No	Mood Swings	□ Yes	□ No
Cancer	□ Yes	□ No	Neck Pain	□ Yes	□ No
Circulatory/Vascular Disorder	□ Yes	□ No	Numbness/Tingling	□ Yes	□ No
Depression	□ Yes	□ No	Osteoporosis	□ Yes	□ No
Diarrhea	□ Yes	□ No	Sinus Trouble	□ Yes	□ No
Digestive Problems	□ Yes	□ No	Skin Conditions	□ Yes	□ No
Dizziness	□ Yes	□ No	Urinary Difficulty	□ Yes	□ No
Headaches	□ Yes	□ No	Vertigo	□ Yes	□ No
Heartburn/Reflux	□ Yes	□ No	Other: _____	□ Yes	□ No

List all **previous surgeries** and dates:_____
_____

Have you ever had any broken bones/ fractures?_____

List all Medications: □ Pain Meds (over the counter/prescription) □ Birth Control □ Heart Meds
□ Cholesterol Meds □ Antidepressant/ Anti-anxiety Meds □ Recreational Drugs
□ Anti-Inflammatory Meds □ Muscle Relaxers □ Aspirin □ Other _____

If you checked any of the above medications, please **list how long you've been on each medication**, **dosage**, and **who prescribed them** and for **what reason are you taking them**. It is important to let the doctor know in order to ensure proper interpretation of the diagnostic results with your spinal scans:

Name of Medications	**What type**	**Dosage**	**How long**	**Who prescribed**

(Please use the back of this page if you need more space)

Do you have any family history of (please circle all that apply):

Cancer Diabetes Heart Disease Arthritis Other _____

Stress History:

Please indicate whether you have ever experienced stress in any of the following areas. Your answer will enable us to determine which factors have contributed to your present health concerns.

1) Childhood

Repeated/Prolonged Antibiotic use	□ Yes	□ No	Inhaler Use	□ Yes	□ No
Car Accident	□ Yes	□ No	Prescription Medications	□ Yes	□ No
Childhood Illness	□ Yes	□ No	Surgery	□Yes	□ No
Fall/Jump from a height < 3 feet	□ Yes	□ No	Vaccination	□ Yes	□ No
Fall/Jump from a height > 3 feet	□ Yes	□ No	Youth Sports	□ Yes	□ No
Head Trauma	□ Yes	□ No	Other Traumas (physical or emotional)		
			_____		

2) Adulthood

Alcohol Consumption	□Yes	□ No	Inhaler use	□ Yes	□ No
Repeated/Prolonged Antibiotics	□ Yes	□ No	Prescription Medications	□ Yes	□ No
Car Accident	□ Yes	□ No	Smoker	□ Yes	□ No
Coffee Drinker	□ Yes	□ No	Surgery	□ Yes	□ No
Drug Use/Abuse	□ Yes	□ No	Contact Sports	□ Yes	□ No
Fall/Jump from a height	□ Yes	□ No	Extreme Sports	□ Yes	□ No
Head Trauma	□ Yes	□ No	Workplace Stress	□ Yes	□ No
Home Environment Stress	□ Yes	□ No	Other Traumas (physical or emotional)		
			_____		

Lifestyle Information

Do you **exercise**? □ Yes □ No If yes, how much and how often?_____

Do you **smoke**? □ Yes □ No If yes, how much?_____

Do you consume alcohol? □ Yes □ No If yes, how much and how often?_____

Do you drink soft drinks (diet or regular)? □ Yes □ No If yes, how often? _____

How much water do you drink in a day? _____

Do you drink coffee? □ Yes □ No If yes, how much per day? _____

Do would you rate your nutritional habits? □ Great □ Good □ Fair □ Poor

Do you take any vitamins/supplements? □ Yes □ No
If yes, what kind? _____

How many hours of sleep do you usually get? _____ hours

Is it the quality of sleep: □ Great □ Good □ Fair □ Poor

Stress level (personal): □ Low □ Medium □ High
Stress level (at work): □ Low □ Medium □ High

What do you do to relieve or handle your stress? _____

Which best describes your reason for consulting the office? You may choose more than one.

□ I have a specific concern and require help only with this
□ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health
□ I want to be healthier five years from now than I am today

Who is responsible for this account?_____

Relationship to Patient_____

_____

Patient Signature (all information is filled out accurately to the best of my knowledge) Date

**Please be advised, If you have insurance coverage for chiropractic care, we will provide you with all the necessary documentation and statements to be promptly reimbursed directly from your carrier.*