SYNERGY HEALTHCARE
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www.SynHealthCare.com

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Address: _____ City: _____ State: _____

Zip: _____ S.S. #: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Email: _____

Age: _____ Date of Birth: _____ Gender: F M

Marital Status: Single _____ Married _____ Divorced: _____ Widowed: _____

Primary Care Physician: _____

Business/Employer: _____ Type of Work: _____

Height: _____ Weight: _____

Have you been to a chiropractor before? ☐ Yes ☐ No

How did you hear about/find us? _____

REVIEW OF SYMPTOMS

Please Check All That Apply

☐ Neck Pain	☐ Mid Back Pain	☐ Low Back Pain	☐ Headaches	
☐ Herniated Disc	☐ Bulging Disc	☐ Degenerative Disc	☐ Spinal Stenosis	☐ Sciatica
☐ Shoulder Pain	☐ Hand Pain	☐ Leg Pain	☐ Knee Pain	☐ Foot Pain
☐ Foot Numbness	☐ Hand Numbness	☐ Diabetes	☐ Vascular Problems	
☐ Arthritis in Knee	☐ Cancer	☐ Plantar Fasciitis		

Doctor's Initials: _____

MEDICATIONS

List all medications you are currently on. Include all over the counter non-prescription drugs.

Name	Date Started	Date Stopped	Dosage/Frequency

List all vitamins, minerals and any nutritional supplements that you are taking now.

Name	Date Started	Date Stopped	Dosage/Frequency

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced a reoccurrence of an illness, please indicate when or how often under the comments.

ILLNESS	WHEN/ONSET	COMMENTS
Asthma		
Epilepsy, Convulsions, Seizures		
Heart Attack, Angina		
Heart Failure		
Stroke		
Thyroid Disease		

Doctor's Initials: _____

INJURIES	WHEN	COMMENTS
Neck/Back Injury		
Broken Bones		
Head Injury		
Car Accidents		
Other (Describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Bone Density Test		
CAT/CT Scan (please indicate region)		
EMG/NCV		
MRI (please indicate region)		
X-rays (please indicate region)		
SUGERIES	**WHEN**	**COMMENTS**
Neck or Back		
Other (Describe)		
FAMILY HISTORY	**WHO**	**COMMENTS**
Heart Disease		
Cancer		
Diabetes		
Autoimmune Disease		
Mental Illness		

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

Doctor's Initials: _____

REVIEW OF SYMPTOMS

Check ( ) those items that applied to you in the **past**. **Circle** those that ***presently*** apply.

GENERAL:

☐ Fever
☐ Difficulty falling asleep
☐ Swollen Glands
☐ Fatigue

NECK:

☐ Stiffness
☐ Swelling
☐ Lumps

SKIN:

☐ Rashes
☐ Psoriasis
☐ Bruise easily
☐ Changing Moles
☐ Skin cancer
☐ Shingles

NOSE/SINUSES:

☐ Infection
☐ No sense of smell

MOUTH:

☐ TMJ Issues
☐ Fever blisters

THROAT:

☐ Difficulty swallowing
☐ Frequent hoarseness
☐ Enlarged glands

GASTROINTESTINAL:

☐ Indigestion
☐ Heartburn
☐ Gallstones
☐ Abdominal Pains/Cramps
☐ Acid Reflux
☐ Rectal Bleeding
☐ Bloody stools
☐ Ulcers
☐ Diarrhea

HEAD:

☐ Poor Concentration
☐ Headaches:
  ☐ Severe
  ☐ Migraine
  ☐ Occipital
  ☐ Frontal
☐ Forgetfulness

EYES:

☐ Visual hallucinations
☐ Eye pains
☐ Floaters in eyes
☐ Blurred vision
☐ Cataracts

EARS:

☐ Aches
☐ Ringing
☐ Deafness/Hearing loss
☐ Frequent infections

CIRCULATION/RESPIRATION:

☐ High Blood Pressure
☐ Chest pain
☐ Shortness of breath
☐ Irregular Heart Beat
☐ High Cholesterol
☐ Emphysema
☐ Dizziness upon standing
☐ Palpitations
☐ Night sweats
☐ Murmurs
☐ Heart Enlargement
☐ Prior Heart Attack? ____/____/_____

KIDNEY/URINARY TRACT:

☐ Blood in urine
☐ Problem passing urine
☐ Night time urination
☐ Painful/Burning urination
☐ Kidney stones/Infections
☐ Loss of bladder control
☐ Urgency/Hesitancy/Change in Urinary Stream

Doctor's Initials: _____

MEN'S HISTORY (for men only):

☐ Prostate cancer
☐ Have you had a PSA done?
Yes ____ No ____
☐ Prostate enlargement
☐ Genital Pain
☐ Hernia

WOMEN'S HISTORY (for women only):

☐ Endometriosis
☐ Non-period bleeding
☐ Lumps in breasts
☐ Partial/Total Hysterectomy
☐ Breast Cancer
☐ Ovarian Cysts
☐ Pregnant
☐ Fibroid tumors/Uterus
☐ Heavy Bleeding

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No ____

How much? _____ Number of years? _____ If not a current user, year quit? _____

ALCOHOL INTAKE

How often do you consume alcohol?

☐ 0-5 drinks per week

☐ >5 drinks per week

EXERCISE HISTORY

Do you exercise regularly? Yes ____ No ____

If yes, please indicate:

Type of Exercise	Times/week				Length of Session			
	1x	2x	3x	4x+	<15	15-30	30-45	>45
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, soccer, basketball)								
Other (please indicate)								

"I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct: I am not attempting to investigate Synergy Healthcare as a representative of any agent or entity, or any insurance company or other organizational entity or person."

Name: _____ **Date:** _____

Signature: _____

Doctor's Initials: _____