Synergy Holistic Health Center
7309 US Hwy 42, Suite A, Top Floor, Florence, KY 41042
(859) 525-5000 | www.synergyholistichealth.com

Chiropractic Intake Form

Date:_____

Name: _____ Sex: F ☐ M ☐

Date of Birth: _____ Drug Allergies: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone Number (___)_____ (___)_____ (___) _____
Home Cell Work

Please circle the phone number(s) above we may use to leave messages and confirm your appointments

E-Mail Address: _____ SSN#: _____

How did you hear about Synergy or me? _____

Family/Friend(who):_____ Internet: _____ Other:_____

Healthcare Provider: _____

Please list all medications you currently take _____

_____

_____

Emergency Contact Name: _____ Phone: _____Relationship:_____

By signing this form, I give my consent to receive chiropractic treatment. I understand I may discontinue my treatment at any time. I realize that the treatment is given for the well-being of my mind and body. All information will be kept in strict confidence. Information may be shared among practitioners at Synergy. I have stated all medical conditions that I am aware of and will update the doctor of any changes in my health status.

Signature: _____ Date:_____

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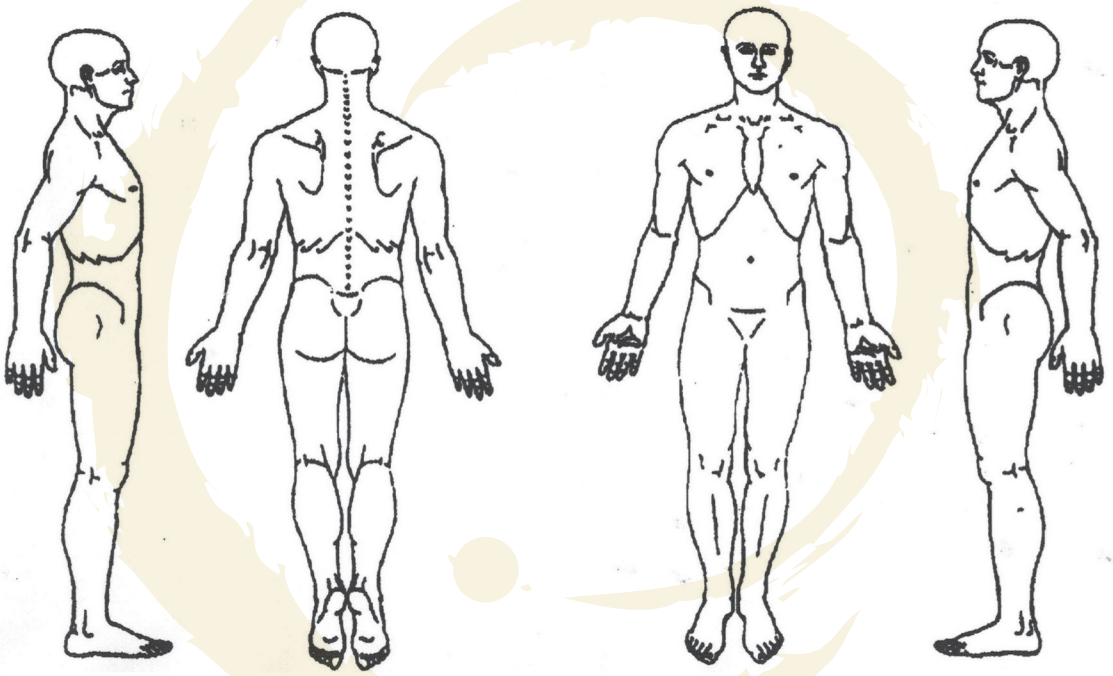
Please Draw the location and type of pain on the figures below. Use the key below for the pain type.

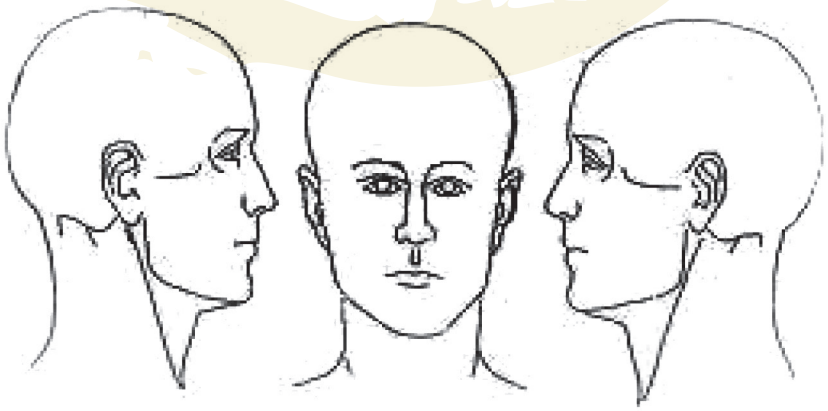
Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^	====	oooo	. . . . .	/ / / /	XXX
^^^^	====	oooo	. . . .	/ / / /	XXX

Right



Left

Right



Left

Please make a slash through this line to indicate your level of pain.

No Pain |————————————————————————————————————| Worst Pain Possible

Signature _____ Date_____

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FAMILY HISTORY

No	Yes	
☐	☐	Diabetes
☐	☐	Thyroid disease
☐	☐	Tuberculosis
☐	☐	Kidney Disease
☐	☐	Heart Disease
☐	☐	Musculoskeletal
☐	☐	Other

GENERAL

- ☐ ☐ Weight change
- ☐ ☐ Fever/Chills
- ☐ ☐ Sweats
- ☐ ☐ Allergies
- ☐ ☐ Anemia
- ☐ ☐ Bleeding/bruising

EYES, EARS. NOSE, THROAT

- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Difficulty hearing
- ☐ ☐ Earache
- ☐ ☐ Ear Discharge
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Nosebleeds
- ☐ ☐ Sinus infection

CARDIOVASCULAR

- ☐ ☐ Chest discomfort
- ☐ ☐ Hardening of the arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over the heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Slow heart beat
- ☐ ☐ Swelling of ankles
- ☐ ☐ Previous heart disease
- ☐ ☐ Rheumatic fever

RESPIRATORY

- ☐ ☐ Chest Pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

GASTROINTESTINAL SYSTEM

- ☐ ☐ Nausea/vomiting
- ☐ ☐ Spitting up blood
- ☐ ☐ Peptic ulcer disease
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Indigestion/heartburn
- ☐ ☐ Abdominal pain
- ☐ ☐ Abdominal; swelling
- ☐ ☐ Bloody stool/black stool
- ☐ ☐ Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Hernia (specify type)_____
- ☐ ☐ Hemorrhoids
- ☐ ☐ Gallbladder trouble
- ☐ ☐ Liver trouble
- ☐ ☐ Pancreatitis

URINARY

- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inability to control bladder
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Urinary stream flow abnormality
- ☐ ☐ Pus in urine
- ☐ ☐ Flank pain
- ☐ ☐ Urinary tract infections

ENDOCHRINE SYSTEM

- ☐ ☐ Heat/cold intolerance
- ☐ ☐ Thyroid problems
- ☐ ☐ Diabetes

SKIN

- ☐ ☐ Bruises easily
- ☐ ☐ Dryness/itching
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Skin cancer
- ☐ ☐ Varicose Veins

FOR WOMEN ONLY

- ☐ ☐ Breast self exam (BSE)
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstruation
- ☐ ☐ Vaginal discharge
- ☐ ☐ Pregnancies
- ☐ ☐ Date of last period _____
- ☐ ☐ Mammogram
- ☐ ☐ Genital lesions

FOR MEN ONLY

- ☐ ☐ Breast self exam
- ☐ ☐ Prostate trouble
- ☐ ☐ Date of last prostate exam _____
- ☐ ☐ Testicular self exam (TSE)
- ☐ ☐ Testicular mass/pain
- ☐ ☐ Sexually transmitted disease