

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 _____

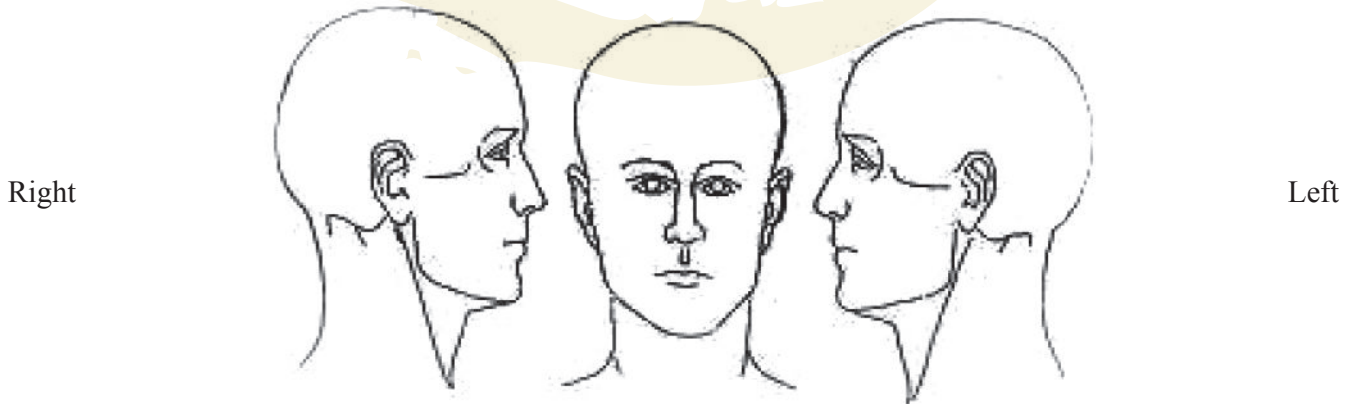
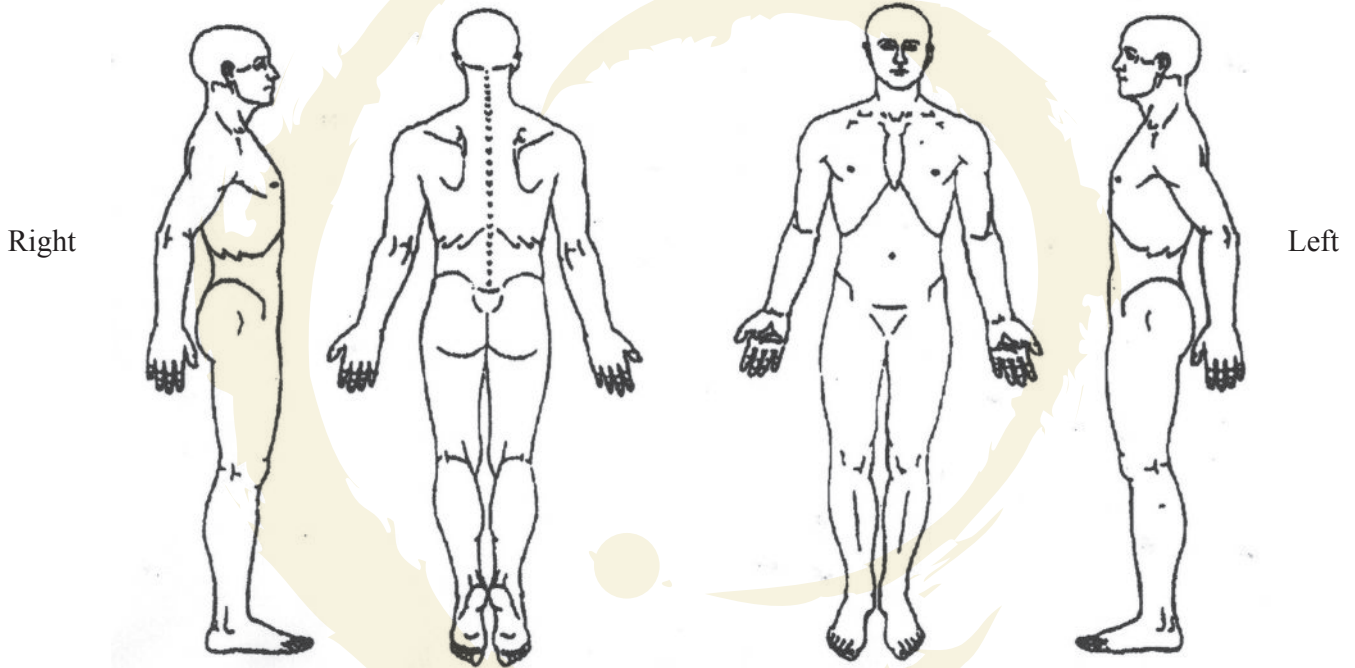
Emergency Contact Name: _____ Phone: _____ Relationship: _____

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: _____

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



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

No Pain |-----| Worst Pain Possible

Signature _____ Date _____

Synergy Holistic Health Center

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(859) 525-5000 | www.synergyholistichealth.com

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

ENDOCRINE 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