CYNERGY CHIROPRACTIC PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.
THANK YOU.

Name_____ Birthday_____Sex ☐M ☐ F

Address_____ City_____ Zip_____

Email _____ Home Phone _____Work_____ Cell_____

Marital Status: ☐M ☐S ☐D ☐W Children, Ages_____ Spouse's Name_____
Your Occupation_____ Your Employer_____

Who referred you to us?_____ How else did you hear about us?_____

Emergency Contact & Relation _____

What is your major complaint?_____
_____
How long have you had this condition?_____
Have you had this or similar conditions in the past? _____
Do any positions make it feel worse?(Please Describe)_____
Do any positions make it feel better?(Please Describe)_____

Is this condition: ☐ Improved ☐ Unchanged ☐ Getting Worse

Other doctors or therapists whom have treated THIS condition:
_____

What do you think caused this condition?_____

List surgical operations and years:_____

_____

Do you have a family physician? (Please include doctor's name and office)_____

_____

May we have authorization to contact your family physician?
_____

Medications, dosage and

frequency:_____

_____

Have you been in an auto accident or had any other personal injury? ☐ Y ☐ N
Describe _____

_____

Signature_____ **Date** _____

Parent/Guardian_____**Date** _____

REVIEW OF SYSTEMS Check only the ones you now have or have had in the past.

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐

SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
Weakness	☐	☐

HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	_____	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐

EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐

NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐

MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐

NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐

BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Bloated	☐	☐

LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐

HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐

BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐

GENITOURINARY		
Urgency	☐	☐
Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	_____	
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐

Contraception Type _____

Age at First Period _____

Duration of Cycle _____ Days

Duration of Flow _____ Days

No. of Pregnancies _____

No. of Births _____

No. of Abortions _____

Menstrual Flow ☐ Heavy ☐ Mod ☐ Light

Last Period _____

Last Pap Smear _____

Last Vaginal Exam _____

Last Mammogram _____

Last Prostate Exam _____

NAME_____

NEUROLOGIC	NOW	PAST
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
In-co-ordination	☐	☐
Loss of Facial	☐	☐
Weak Grip	☐	☐
Paralysis	☐	☐
Difficulty Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Drug Dependent	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

ENDOCRINE

Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION/VACCINATION

DPT	☐
Mumps	☐
Smallpox	☐
Typhoid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

BLOOD TYPE

A+ ☐ A- ☐
B+ ☐ B- ☐
AB+ ☐ AB- ☐
O+ ☐ O- ☐
Other ☐

BLOOD TRANSFUSIONS

Date_____
Date_____
Date_____
Date_____

PAST MEDICAL HISTORY. Check only the one you have had in the past.

Hay Fever	☐	Epilepsy	☐
Mumps	☐	Paralysis	☐
Rheumatic Fever	☐	Polio	☐
Allergies	☐	Mental Illness	☐
Angina	☐	Alcoholism	☐
Cancer	☐	Depression	☐
Tumor	☐	Nervous Breakdown	☐
Blood Disease	☐	Migraine	☐
Leukemia	☐	Gout	☐
Heart Trouble	☐	Hemorrhoids	☐
Varicose Veins	☐	Prostate Problems	☐
Phlebitis	☐	Sexual Problems	☐
Hypertension	☐	Gonorrhea	☐
Stroke	☐	Syphilis	☐
Ulcers	☐	Diabetes	☐
Jaundice	☐	Bladder Trouble	☐
Skin Trouble	☐	Kidney Stones	☐
Gallstones	☐	Kidney Infections	☐
Liver Trouble	☐	Diabetes	☐
Hepatitis	☐	Bladder Trouble	☐
Parasites	☐	Dysentery	☐
Osteoporosis	☐		

Date of Last Chest X Ray _____ ☐ Normal ☐ Abnormal
Last TB Skin Test _____ ☐ Normal ☐ Abnormal
Allergies: _____
_____
_____
_____

Patient Name _____ Date _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

SOCIAL HISTORY Check the boxes and fill in.

Current Weight _____ Have you recently lost or gained weight? ☐ Y ☐ N If Yes, how many pounds?_____

Mental Work	☐ Heavy	☐ Moderate	☐ Light	Hours per day_____
Physical Work	☐ Heavy	☐ Moderate	☐ Light	Hours per day_____
Exercise	☐ Heavy	☐ Moderate	☐ Light	Hours per week _____
Smoking	☐ Current	☐ Previous	☐ Packs/Day	# of Years _____
Alcohol	Beer/Week_____	Liquor/Week_____	Wine/Week_____	# of Years_____
Caffeine	Cups/Day_____	# of Years_____		
Aspirin	# / Day_____	# of Years_____	Others_____	

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE RIGHT. Use the following symbols:

Aches ΔΔΔΔ Numbness = = = = Pins/Needles ○○○○ Burning XXXX Stabbing ////

MARK AN "X" ON THE LINES:

How bad are your symptoms now?

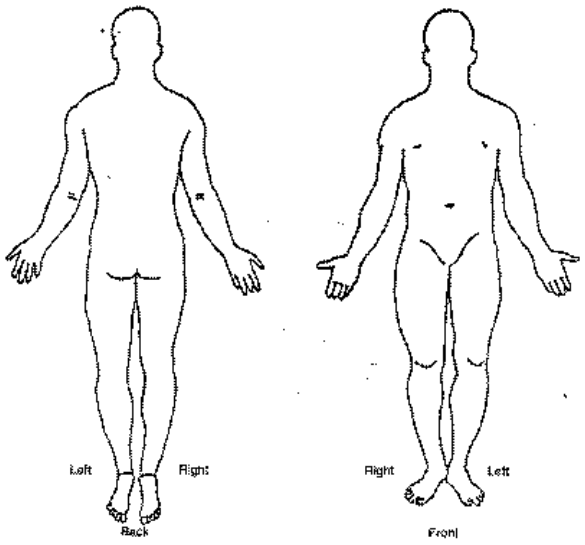
[_____]

None Most Severe

How bad have they been in the past?

[_____]

None Most Severe



Please Print Patient Name_____Date_____