Synergy Chiropractic & Health Rehabilitation Centr
409 - 3950 14th Ave
Markham, ON L3R 0A9
905 479 3030

Introduction

Contact

First Name _____ Last Name _____

Address _____

City _____ Prov _____ Postal _____

Home Phone _____ Cell Phone _____

Other Phone _____ Email _____

Gender Male Female Birthdate _____

Height _____ Shoe Size _____ Weight _____

Marital Status Single Married Divorced Widowed

Spouse _____ Num. of Children _____ Names/Ages _____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about us? None Patient Physician Attorney Advertisement

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Family Physician _____ Date of Last Visit _____

Physician Phone _____

Work Status Full Time Part Time Disability Student Retired Unemployed

Employer _____ Occupation _____ Employer Phone _____

Employer Address _____

Have you missed work due to this injury? Yes No

Missed work start date? _____ Return or anticipated return date _____

Condition

The Symptoms that have prompted you to seek care today include: _____

Have you seen other doctors for this condition? Yes No

Prior Interventions Acupuncture Chiropractic Heat Homeopathic Ice Massage Medication OTC Meds Physiotherapy Surgery Other

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What is the condition related to? Auto Accident Home Injury Sports Injury Work Injury Other

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When did your problem first start? _____

Have you had this condition before? Yes No

Does the pain radiate or travel to other parts of the body? Yes No

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Does anyone from your family suffer from the same condition? Yes No

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What makes the condition worse? Bending Coughing Defecation Lifting Sitting Sneezing Stairs Standing Walking Other

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What makes the condition better? Bed Rest Heat Ice Massage Medication Other

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Does this condition affect employment? Yes No

Does this condition affect recreation? Yes No

Does this condition affect household? Yes No

Does this condition affect personal? Yes No

Does this condition affect sleep? Yes No

What else should we know about your current condition? _____

Rate the severity of your pain from 0 to 10



Pain Duration Constant Intermittent

Current Medications Blood Pressure Insulin Muscle Relaxants Nerve Pills Pain Other

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Supplements Yes No

Sleep Position Back Left Side Right Side Stomach

Hours of sleep per night? (1-24)_____

Have you had x-rays in the last six months? Yes No

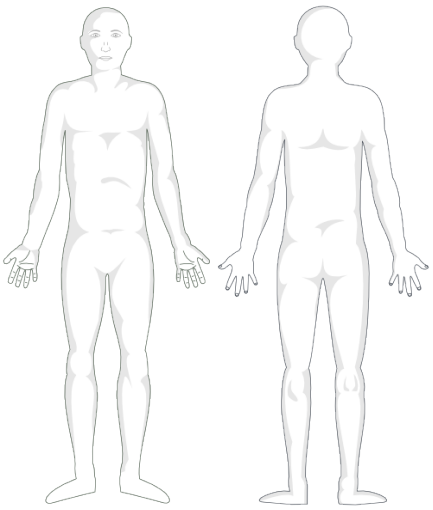
I realize that x-ray examinations may be hazardous to an unborn child. I certify to the best of my knowledge I am not pregnant.

Yes No

Last Cycle: _____

Pain

Please Select the Area(s) that you are experiencing pain?



Systems

Select options below indicating age at diagnosis and other relevant details.

Musculoskeletal Osteoporosis

Back Problems

Knee Injuries

Arthritis

Hip Disorders

Foot/Ankle Pain

Scoliosis

TMJ Issues

Shoulder Problems

Elbow/Wrist Pain

Neck Pain

Poor Posture

Neurological Anxiety

Headaches

Dizziness

Depression

Numbness

Pins and Needles

Cardiovascular High Blood Pressure

Poor Circulation

High Cholesterol

Low Blood Pressure

Chest Pain

Respiratory	Asthma
	Shortness of Breath
	Emphysema
	Apnea
	Pneumonia
	Allergies
Digestive	Anorexia or Bulimia
	Constipation
	Food Sensitivities
	Ulcer
	Diarrhea
	Heartburn
Sensory	Blurred Vision
	Nose Bleeds

	Chronic Ear Infections
	Ringing in Ears
	Sore Throat
	Loss of Smell
	Hearing Loss
Integumentary	Skin Cancer
	Rash
	Acne
	Psoriasis
	Bruise Easily
	Hair Loss
	Eczema
	Slow Healing
Endocrine	Thyroid Issues
	Swollen Glands

	Low Blood Sugar
	Immune Disorder
	Low Energy
	Frequent Infection
Genitourinary	Kidney Stones
	Prostate Issues
	Bedwetting
	Infertility
	PMS Symptoms
General	Fainting
	Loss of Appetite
	Sudden Weight Gain
	Fatigue
	Loss of Sleep

Weakness

Sudden Weight Loss

History

Personal Illness History Aids Alcoholism Allergies Arteriosclerosis Cancer Chicken Pox Diabetes Epilepsy Glaucoma Goiter Gout Heart Disease Hepatitis HIV Positive Malaria Measles Multiple Sclerosis Mumps Polio Rheumatic Fever Scarlet Fever STD Stroke Tuberculosis Typhoid Ulcer Other

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Surgery/Trauma History Cancer Back Surgery Bypass Surgery Hernia Other

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Fractures Yes No

Auto Accident Yes No

Spinal Injury Yes No

Hospitalization Yes No

Alcohol Use None Daily Weekly

Coffee Use None Daily Weekly

Tobacco Use None Daily Weekly

Exercise None Daily Weekly

Pain Reliever None Daily Weekly

Soft Drinks None Daily Weekly

Water Intake None Daily Weekly

Family History

Mother Age

Age At Death

Illness

Health Good Bad

Father Age

Age At Death

Illness

Health Good Bad

Sibling Age

Age At Death

Illness

Health Good Bad

Sibling Age

Age At Death

Illness

Health Good Bad

Finalize

What is the most significant thing you can do to improve your health? _____

How committed are you at achieving your maximum health potential



How do you want us to handle your problem? Temporary Relief Maximum Correction

Please Read the following carefully before signing.

**After agreeing, please Sign and Submit

Signature