

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**

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

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

\_\_\_\_\_  
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

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

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

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

\_\_\_\_\_  
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

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What else should we know about your current condition? \_\_\_\_\_

Rate the severity of your pain from 0 to 10



Pain Duration    Constant    Intermittent

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Current Medications    Blood Pressure    Insulin    Muscle Relaxants    Nerve Pills    Pain    Other

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Supplements    Yes    No

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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

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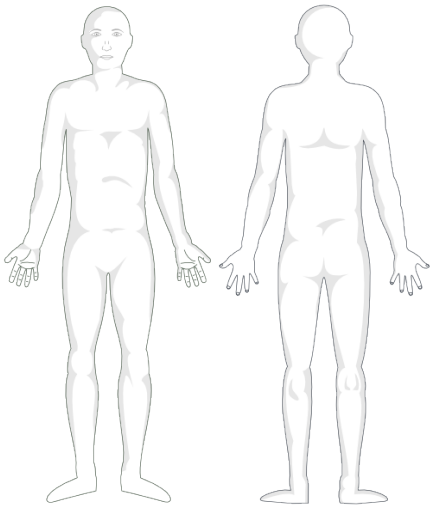
I realize that x-ray examinations may be hazardous to an unborn child. I certify to the best of my knowledge I am not pregnant.

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

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Elbow/Wrist Pain

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Neck Pain

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Poor Posture

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Neurological    Anxiety

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Headaches

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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

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Constipation

---

Food Sensitivities

---

Ulcer

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Diarrhea

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Heartburn

---

Sensory    Blurred Vision

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Nose Bleeds

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## Chronic Ear Infections

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Ringing in Ears

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Sore Throat

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Loss of Smell

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Hearing Loss

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---

Integumentary   Skin Cancer

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Rash

---

---

Acne

---

---

Psoriasis

---

---

Bruise Easily

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Hair Loss

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Eczema

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Slow Healing

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Endocrine   Thyroid Issues

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Swollen Glands

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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

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Fatigue

---

Loss of Sleep

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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

Surgery/Trauma History   Cancer   Back Surgery   Bypass Surgery   Hernia   Other

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

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

0 1 2 3 4 5 6 7 8 9 10

Not Interested Very Interested

Very Interested

Please Read the following carefully before signing.

**\*\*After agreeing, please Sign and Submit**

Signature