

Today's Date: \_\_\_\_\_

Referred By: \_\_\_\_\_

*Syn Chiropractic, Inc.*  
*Progressive Family Wellness Center*  
*Confidential Chiropractic Questionnaire*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F

Phone: (H) \_\_\_\_\_ (w) \_\_\_\_\_ (cell) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: S M D W / Spouse's Name \_\_\_\_\_

Children  No  Yes ages: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_ Hours worked / week \_\_\_\_\_

**Health Information:**

What are your **current health problems, challenges, and or conditions** (major or minor)?

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Once these problems have been resolved, what are your future **health goals**? \_\_\_\_\_

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**When** did this/these problem(s) start and **how long** have you had this/them?

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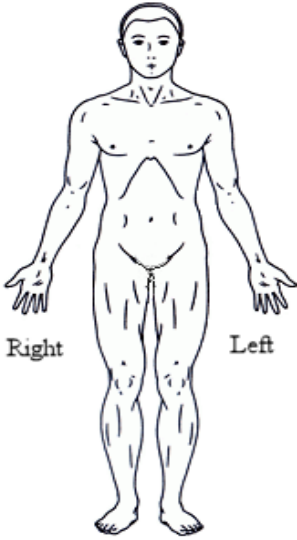
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**Current Health**

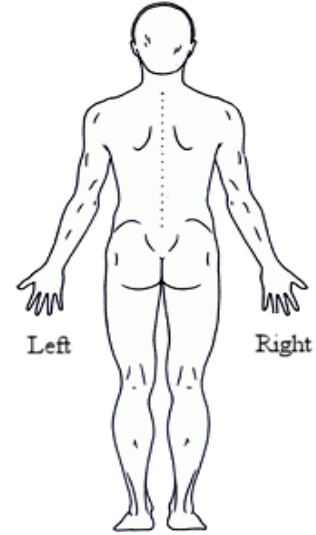
Is it    getting worse    improving    intermittent    constant    can't say

Where is the problem? Please use the illustrations and lines below to explain



Front \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Back \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Do You have:**    pain    numbness    tingling    aches \_\_\_\_\_

**Is your pain:**    sharp    dull    throbbing    constant    intermittent \_\_\_\_\_

**Are your symptoms affected by:**

sitting    standing    walking    bending    lying down    weather

**Please explain:** \_\_\_\_\_

**Do you feel:**

cramps    burning    other    swelling    stiffness   \_\_\_\_\_

**Do your symptoms interfere with:**

It interferes with (circle all that apply):   work   family   sleep   sex   sports   recreation

housework   happiness   ability to relax   concentration   other \_\_\_\_\_

On a scale of 1-10 (1 least, 10 most), please circle and rate:

**The severity of your symptoms**   1   2   3   4   5   6   7   8   9   10

Have you had previous care for this condition?  No  Yes

Is it getting worse?  No  Yes, How? \_\_\_\_\_

At its worst, how does it feel? \_\_\_\_\_

Do you want to get rid of this condition?  Yes  No

Have you had **previous Chiropractic Care**?  Yes  No This year?  Yes  No

Were you ever put on a **Spinal correction and stabilization program**?  Yes  No

Which doctor did you complete the program with? \_\_\_\_\_

Who was the last doctor who created a **health development plan** for you if any? \_\_\_\_\_

Did you follow all of the Doctor's recommendations?  Yes  No  I was never put on a health plan

How long were you able to stay on the health development plan? \_\_\_\_\_

What were the results if any? \_\_\_\_\_

What other wellness professionals are currently a part of your health care team?

Massage Therapist  Acupuncturist  Naturopath  Homeopath  Other \_\_\_\_\_

How many Medical Doctor's office visits did you and your family have last year?

None  Less than 5  More than 5  More than 10

### **Past Health History:**

Please check all of the following health concerns you have experienced, even if you do not think that your answers relate to your present health concern.

Allergies  Yes  No

Anxiety  Yes  No

Asthma  Yes  No

Arthritis  Yes  No

Back Pain  Yes  No

Bladder Problems  Yes  No

Cancer  Yes  No

Circulatory/Vascular Disorder  Yes  No

Depression  Yes  No

Diarrhea  Yes  No

Digestive Problems  Yes  No

Dizziness  Yes  No

Headaches  Yes  No

Heartburn/Reflux  Yes  No

Heart Condition:  Yes  No

Immune System Disorder  Yes  No

Infertility  Yes  No

Kidney Disease  Yes  No

Menstrual Cramps  Yes  No

Mood Swings  Yes  No

Neck Pain  Yes  No

Numbness/Tingling  Yes  No

Osteoporosis  Yes  No

Sinus Trouble  Yes  No

Skin Conditions  Yes  No

Urinary Difficulty  Yes  No

Vertigo  Yes  No

Other: \_\_\_\_\_  Yes  No

List all **previous surgeries** and dates: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any broken bones/ fractures? \_\_\_\_\_

List all Medications:  Pain Meds (over the counter/prescription)  Birth Control  Heart Meds  
 Cholesterol Meds  Antidepressant/ Anti-anxiety Meds  Recreational Drugs  
 Anti-Inflammatory Meds  Muscle Relaxers  Aspirin  Other \_\_\_\_\_

If you checked any of the above medications, please **list how long you've been on each medication, dosage, and who prescribed them** and for **what reason are you taking them**. It is important to let the doctor know in order to ensure proper interpretation of the diagnostic results with your spinal scans:

Name of Medications	What type	Dosage	How long	Who prescribed

(Please use the back of this page if you need more space)

Do you have any family history of (please circle all that apply):

Cancer      Diabetes      Heart Disease      Arthritis      Other \_\_\_\_\_

**Stress History:**

Please indicate whether you have ever experienced stress in any of the following areas. Your answer will enable us to determine which factors have contributed to your present health concerns.

**1) Childhood**

Repeated/Prolonged Antibiotic use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inhaler Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Car Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prescription Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Childhood Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall/Jump from a height < 3 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaccination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall/Jump from a height > 3 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Youth Sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Traumas (physical or emotional)	_____

**2) Adulthood**

Alcohol Consumption	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inhaler use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Repeated/Prolonged Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prescription Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Car Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coffee Drinker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Use/Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall/Jump from a height	<input type="checkbox"/> Yes <input type="checkbox"/> No	Extreme Sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Workplace Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Environment Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Traumas (physical or emotional)	_____

**Lifestyle Information**

Do you **exercise**?  Yes  No If yes, how much and how often? \_\_\_\_\_

Do you **smoke**?  Yes  No If yes, how much? \_\_\_\_\_

Do you consume alcohol?  Yes  No If yes, how much and how often? \_\_\_\_\_

Do you drink soft drinks (diet or regular)?  Yes  No If yes, how often? \_\_\_\_\_

How much water do you drink in a day? \_\_\_\_\_

Do you drink coffee?  Yes  No If yes, how much per day? \_\_\_\_\_

Do you rate your nutritional habits?  Great  Good  Fair  Poor

Do you take any vitamins/supplements?  Yes  No  
If yes, what kind? \_\_\_\_\_

How many hours of sleep do you usually get? \_\_\_\_\_ hours

Is it the quality of sleep:  Great  Good  Fair  Poor

Stress level (personal):  Low  Medium  High

Stress level (at work):  Low  Medium  High

What do you do to relieve or handle your stress? \_\_\_\_\_

**Which best describes your reason for consulting the office? You may choose more than one.**

- I have a specific concern and require help only with this
- I want to ensure that my health concerns do not become an ongoing problem that will impact my future health
- I want to be healthier five years from now than I am today

**Who is responsible for this account?** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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Patient Signature (all information is filled out accurately to the best of my knowledge)

Date

*\*Please be advised, If you have insurance coverage for chiropractic care, we will provide you with all the necessary documentation and statements to be promptly reimbursed directly from your carrier.*