SYNERGY Wellness Group

Patient No:

## Your Confidential Health Profile

First name: Last name:

Address: City: Province: Postal code:

Email address:

Home phone: Work phone: Mobile phone:

Gender: Marital status: Single Married Divorced Widowed

Date of birth (MM/DD/YYYY): Spouse/Partners name:

Children's name & ages:

Occupation: Employer:

Have you previously seen a Chiropractor? No Yes Name:

Last visit?

How did you hear about our office?

Please mark an "X" where you believe your health is and an "O" where you would like to be:

| 0-59 Very Challenged | 60-69 Challenged | 70-79 Transition | 80-89 Good | 90-100 Excellent |
|---|---|---|---|---|
| | | | | |

## Current Health Profile

| | List health concerns according to their severity: | Severity 1 = mild 10 = worst | When did this episode start? | If you've had this condition before, when? | Are symptoms constant or intermittent? |
|---|---|---|---|---|---|
| 1. | | | | | C I |
| 2. | | | | | C I |
| 3. | | | | | C I |
| 4. | | | | | C I |

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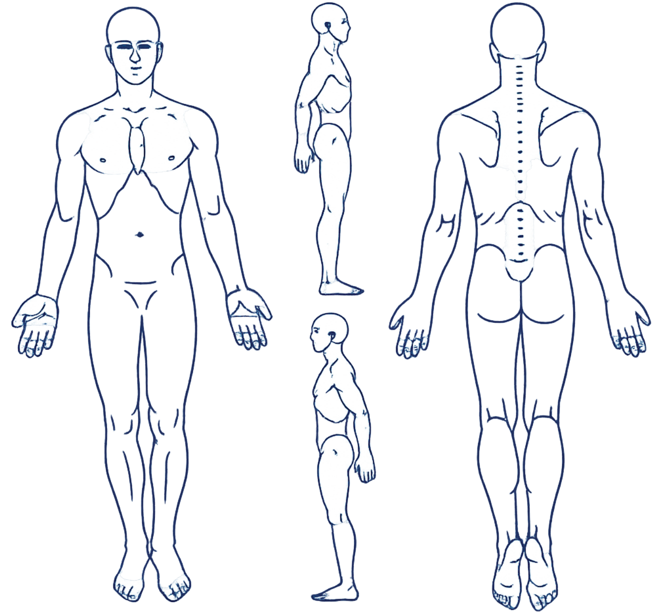
## Current Health Profile Continued

Using the appropriate letter from the legend below, please mark any and all areas where you feel pain, numbness, spasm, tenderness or any other sensation that is unusual or abnormal: Use the Tab key and the Space Bar to indicate where you are experiencing concerns/symptoms.

| | | | |
|---|---|---|---|
| **AA** | Aching | **SP** | Sharp |
| **BB** | Burning | **SH** | Shooting |
| **CC** | Cramps | **SB** | Stabbing |
| **DD** | Dull | **ST** | Stiffness |
| **MM** | Muscle Spasm | **SW** | Swelling |
| **NN** | Numbness | **TT** | Throbbing |
| **PN** | Pins & Needles | | |



Please briefly describe your chief concern, including the effect it has had on your life:

Does the pain travel/radiate anywhere? ☐ No ☐ Yes Please describe below:

Since the problem started, is it: ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse?

What have you done that has helped you feel better?

What have you done for it that was of NO help?

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Exercise/Walking/Sports ☐ Hobbies

☐ Positive mental attitude ☐ Other (Describe)

Other health care professional seen for this condition:

| Name/Profession: | Date: | Diagnosis: | Treatment: | Results: |
|---|---|---|---|---|
| | | | | |

Were x-rays taken? ☐ No ☐ Yes Area of body: Date (MM/DD/YYYY):

Current medications: Supplements:

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## General Health Profile

Check all symptoms you have ever had, even if they do not seem related to your current problem:

- Neck pain
- Headaches
- Dizziness/fainting
- Loss of concentration
- Buzzing in ears
- Brain fog
- Tension
- Pins and needles in arms
- Numbness in fingers
- Shoulder pain
- Mid back pain
- Chest pain
- Heartburn
- Difficulty breathing
- Sleeping problems
- Cold hands
- Cold feet
- Low back pain
- Pins and needles in legs
- Numbness in toes
- Loss of balance
- Urinary problems
- Leg/foot pain
- Digestive problems
- Skin conditions
- Allergies
- Loss of smell
- Loss of taste
- Sinus trouble
- Fatigue
- Depression
- Mood swings
- TMS pain/stiffness
- Seizures
- Heart problems
- Hip pain
- High blood pressure
- Arm/hand pain
- Unexplained weight loss/gain
- ADD/ADHD

**Women only:**

- Menstrual pain
- PMS

Pregnant? No Yes

## Family Health Profile

If we were meeting here 3 years from today – and you were looking back over those 3 years to today - what has to have happened concerning your health, for you to feel happy about your progress?

What are the 3 biggest things holding you back from achieving the level of health you want?

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## Stress Profile

Chronic physical, chemical and emotional stress is the cause of most health problems. Please review these common stresses and mark an “X” in the box when you experienced it in your life. P is for Past and C for Current. Your answers will help enable us to determine what contributed to your present health.

| **Physical stress:** | | | **Explanation:** |
|---|---|---|---|
| 1. Accidents (auto, work related, falls or other) | P | C | |
| 2. Surgical operations | P | C | |
| 3. Strains, sprains and/or broken bones | P | C | |
| 4. Poor posture (excessive computer work, driving) | P | C | |
| 5. Poor sleeping habits | P | C | |
| 6. Sports injuries | P | C | |
| 7. Heavy lifting and/or bending | P | C | |
| 8. Lack of exercise | P | C | |

| **Chemical stress:** | | | **Explanation:** |
|---|---|---|---|
| 1. Take prescription or over the counter medication | P | C | |
| 2. Consume alcohol/recreational drugs | P | C | |
| 3. Use tobacco products | P | C | |
| 4. Poor diet (fast food, flour, white sugar) | P | C | |
| 5. Environmental pollution | P | C | |

| **Emotional stress:** | | | **Explanation:** |
|---|---|---|---|
| 1. Serious illness or death of a loved one | P | C | |
| 2. Financial stress | P | C | |
| 3. Work stress | P | C | |
| 4. Relationship stress | P | C | |
| 5. Low self-esteem | P | C | |

Our goal is to provide the safest and most effective care possible. In order to do so, it is important that we perform a series of tests. I consent to a complete examination as the doctor deems necessary.

Signature: Date (MM/DD/YYYY):