Dr. Amanda Thompson, D.C., PAK

SYNERGY
CHIROPRACTIC

Patient Intake/ Medical History

PATIENT INFORMATION

Name: _____ Date: _____
First Middle Last

Date of Birth: ____ /____ /____ Age: _____ Gender: M or F _____
mm dd yy

Height: _____ Weight: _____

Home Address _____

_____

Home Phone Number: _____

Work or Cell Number: _____ (circle one)

At which phone number may we leave messages relating to our visits? _____

Email Address: _____

Occupation: _____

How did you hear about our clinic? _____

EMERGENCY CONTACT

Name _____ Relation _____

Phone: _____ Home/ Work/ Cell (specify)

Please rank current and ongoing health problems by priority and fill in the other boxes as completely as possible:

Describe Problem	Mild/Moderate/Severe	Treatment Approach/Comments
1.		
2.		
3.		
4.		
5.		

Please rate your overall stress level on a scale of 0-10 (0=no stress, 10=total stress) _____

CONFIDENTIAL HEALTH HISTORY

Y= Yes (currently or in the past year) **P**= Past (leave blank if not applicable)

GENERAL

Condition/Symptom (indicate Y or P)	Comments (for doctor's use only)
____ Sweating/Night Sweats	
____ Sleep Disturbances	
____ Fatigue/Weakness	
____ Memory Loss	
____ Weight Loss or Gain	
____ Diabetes	
____ Anemia	
____ Cancer	
____ Eating Disorder	
____ Anxiety/Depression	
____ Psychiatric Treatment	
____ Childhood Vaccinations	
____ Other Vaccinations	
_____ Date of Last Physical	

GASTROINTESTINAL

____ Hernia	
____ Heartburn/GERD	
____ Belching/Gas/Bloating	
____ Frequent Nausea	
____ Diarrhea	
____ Constipation	
____ Hemorrhoids	
____ Appendicitis	
____ Liver Problems	
____ Gall Bladder Problem	
____ Anal Itching/Discomfort	
Bowel Movements _____ x per week	
____Other	

EYE/EAR/NOSE/THROAT

____ Floaters	
____ Excessive Tearing or Dryness	
____ Glaucoma	
____ Cataracts	
____ Sinus Trouble	
____ Nosebleeds	
____ Bleeding Gums	
____ Mouth Sores	
____ Loss of Taste or Abnormal Taste	
____ Hoarseness	
____ Deafness/Difficulty Hearing	
____ Ringing in Ears	
____ Bruxism: Grinding Teeth at Night	
____ TMJ/Jaw Problems	
____ Dental Fillings	
____ Other	

ENDOCRINE

____ Adrenal Condition (Cushing's, Addison's)	
____ Goiter	
____ Thyroid Condition	
____ Other	

CARDIOVASCULAR

____ Irregular Heartbeat/Palpitations	
____ High Blood Pressure	

____ Atherosclerosis	
____ Pain over Heart/Chest	
____ Heart Attack	
____ Stroke	
____ Ankle Swelling	
____ Varicose Veins	
____ Aortic Aneurysm	
____ Cold Hands/Feet	
____ Other	

PULMONARY

____ Seasonal Allergies	
____ Wheezing/Asthma	
____ Chronic Cough	
____ Spitting/Coughing Phlegm	
____ Spitting/Coughing Blood	
____ Pneumonia	
____ Tuberculosis	
____ COPD: Bronchitis or Emphysema	
____ Pneumothorax	
____ Other	

GENITOURINARY

____ Frequent Urination	
____ Blood in Urine	
____ Kidney Stones	
____ Kidney Disease	
____ Urinary Traction Infection	
____ Inability to Control Urination	
____ Difficulty Starting/Stopping Urine Flow	
____ Sexually Transmitted Disease/Infection	
____ Other	

NEUROLOGIC

____ Epilepsy	
____ Twitching	
____ Tremors	
____ Migraines	
____ Headaches	
____ Weakness	
____ Tingling/Numbness	

____ Fainting	
____ Dizziness/Vertigo	
____ Other	

MUSCULOSKELETAL

____ Neck Stiffness/Pain	
____ Pain Between Shoulders	
____ Low Back Pain	
____ Muscle Aches/Soreness	
____ Arthritis	
____ Scoliosis/ Spinal Curvature	
____ Sciatica	
____ Other	

FEMALE REPRODUCTIVE

____ Spotting/Bleeding Between Periods	
____ Excessive Flow	
____ Painful Menses	
____ Irregular Cycles	
____ Menopause ____ Hot Flashes ____ Chills	
____ Hormone Replacement Therapy	
____ Oral Birth Control	
____ Intrauterine Device	
____ Other Forms of Contraception	
____ Breast Lumps	
____ Breast Pain or Tenderness	

MALE REPRODUCTIVE

Date of Last Digital Rectal or PSA Exam? _____

____ Hernias	
____ Testicular Pain/Swelling	
____ Prostate Problems	
____ Erectile Dysfunction	
____ Other	

ACCIDENTS/TRAUMA

____ Motor Vehicle Accidents	

____ Fractures/Dislocations	
____ Concussions	
____ Other	

CHILDHOOD DISEASES

____ Mumps	
____ Measles	
____ Chicken Pox	
____ Rubella	
____ Polio	
____ Rheumatic Fever	
____ Scarlet Fever	
____ Whooping Cough	

FAMILY HISTORY

____ Type I Diabetes	
____ Type II Diabetes	
____ Thyroid Disease	
____ Heart Disease	
____ High Blood Pressure	
____ Cancer	
____ Kidney Disease	
____ Muscle, Bone, or Nerve Disease	
____ Tuberculosis	
____ Other	

IMAGING

Please list any imaging you have had done (x-rays, MRI, Bone scan, etc.) and results:

HOSPITALIZATIONS/SURGERIES

Please list dates and reasons:

MEDICATIONS /SUPPLEMENTS

Please list ALL current prescription and non-prescriptions medications, dosage, and reasons:

ALLERGIES

Please list all allergies (foods, medications, airborne):

NUTRITIONAL STATUS

Do you feel drowsy after meals? _____

Amount of water consumed daily _____

Amount of coffee, soda, or tea consumed daily _____

What kinds of foods or beverages do you crave? _____

Do you have any food sensitivities/dietary restrictions?_____

HABITS

Smoking _____ Packs per day _____ Duration _____

Drinking _____

Recreational Drug Use _____

Other _____

EXERCISE

How often do you exercise? _____

What kind of exercise do you do? _____

I certify that the information I have supplied is accurate to the best of my knowledge.

Name _____

Signature _____

Date _____