

SYNERGY

Sports · Wellness · Institute

Welcome to Synergy Sports Wellness. Carefully complete all of the following health history questionnaires. The accuracy of your answers will help us better diagnose and treat your condition. Thank you for your patience with what may appear to be some duplication in questions in different areas. Each questionnaire has been carefully designed to identify your specific condition.

Patient Name: _____ DOB: _____

Patient Guardian/Representative: _____

How old are you _____ Handed: Right Left Ambidextrous Male Female SSN _____ - _____ - _____

Street Address: _____ Unit/Apt. _____

City: _____ State: _____ ZIP: _____

Phone: (____) _____ Home Mobile Alternate phone: (____) _____

E-mail address: _____ Preferred: Cell Home Text Email

✓ **Emergency Contact Information:** Contact Name: _____

Phone: (____) _____ Home Mobile Alternate phone: (____) _____

Relationship to Patient: _____

✓ **Insurance Information:** **Please Note** We do not bill insurance for any treatment in our facility. This information is exclusively for lab and Rx ordering (if necessary).

Primary Insurance: _____

Insurance cert #: _____ Plan Type: _____ Group #: _____

Guarantor/Member's Name: _____ Guarantor SSN: _____ - _____ - _____

Guarantor's relationship to patient: Husband Wife Parent Date of Birth: _____

✓ **Primary Pharmacy:** Street address: _____ City: _____ State: _____ ZIP: _____

Name: _____ Effective Date: _____

✓ **Primary Mental Health Provider:** Street address: _____ City: _____ State: _____ ZIP: _____

Name: _____ Effective Date: _____

✓ **Primary Physician:** Street address: _____ City: _____ State: _____ ZIP: _____

Name: _____ Effective Date: _____

✓ **How did you hear about us?** _____

Did a physician refer you? Yes No

Physician Name: _____ Physician Address: _____

City: _____ State: _____ ZIP: _____ Telephone Number: (____) _____

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✓ Check as many that apply to you about your reason for visiting us today:

- Headaches
- Sports improvement
- Sleeplessness
- Balance issues
- Head injury
- Nutritional counseling
- Medication management
- Neurological assessment
- Other: _____

If injury occurred, when? ____/____/____ Describe: _____

Another type of accident, trauma, or injury

Neurological problem or disease: (Please explain & include any prior diagnoses)

Diagnostics: (Please list previous diagnostic tests given for current complaints)

✓ CAUSES OF YOUR PAIN SYMPTOMS

Event(s) surrounding the onset of symptoms

Date

Pain Intensity Today

- _____ Better Same Worse
- _____ Better Same Worse
- _____ Better Same Worse

Medication List

Patient taking nonmedications regularly and none in the past 72 hours

| MEDICATIONS (INCLUDE OVER-THE-COUNTER AND HERBAL MEDICATIONS) | DOSE (e.g., strength, # of pills or drops) | ROUTE (e.g., by mouth, # inhaled, on skin) | FREQUENCY (how often) |
|---|---|---|--------------------------|
| <i>Example: Vitamin C</i> | <i>250 mg</i> | <i>By mouth</i> | <i>Once a day</i> |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

Known Food Drug or Environmental Allergies

✓ Patient Name: _____

Date of Birth: ____/____/____

✓ What is the most important thing we can do for you? _____

✓ Expectations.

What are you hoping to gain from your visit to CHC? Circle % relief or increase in function you feel would make treatment worthwhile?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

✓ Brain Health Rank. *How well do you think your brain is functioning?*

Terribly 1 2 3 4 5 6 7 8 9 10 Great

✓ Have you seen anyone else for this condition? No. Yes. If yes, who? _____

✓ Have you lost work days because of this condition? No. Yes. If yes, How Many? _____

✓ How long has this problem been present? Weeks _____ Months _____ Years _____

✓ What do you think is causing your present condition? _____

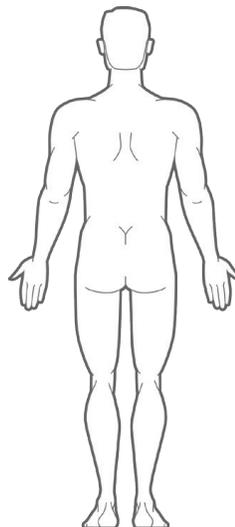
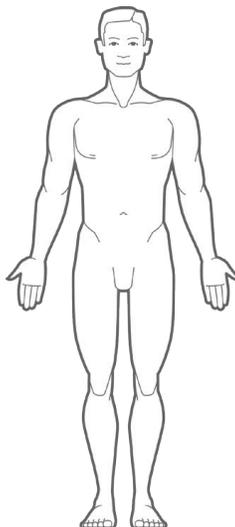
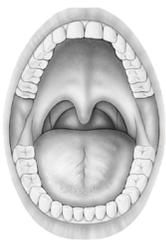
✓ Indicate any other symptoms you think may be important. _____

✓ What are your 3 greatest concerns about your present state of health?

1. _____ 2. _____ 3. _____

✓ On the diagram, please mark the following symptoms, if you are experiencing them:

- "/" stabbing pain
- "B" for burning pain
- "D" for dull pain
- "A" for aching pain
- "N" on or in areas where you have numbness
- "T" in areas where you have tingling
- "St" in areas where you feel stiffness
- "Sw" in areas where you've had swelling
- "C" In areas where you have cramps
- "W" for weakness
- "Tr" for tremor



• Doctor's Notes. _____

Doctor's initials: _____

✓ Patient Name: _____

Date of Birth: ____/____/____

Personal Health History

Please answer the following questions as completely as possible.

✓ Do you have a:

Pacemaker No Yes. Explain _____

Artificial joint No Yes. Explain _____

Artificial heart valve No Yes. Explain _____

Stent No Yes. Explain _____

List all operations and surgeries you may have had, with dates (*month/year*) _____

List any major illness you have had, with dates (*month/year*) _____

Have you had any recent infections, colds, or flu? No Yes. When? ____/____/____

Have you suffered a Head Injury or Concussion? Did you lose consciousness? How long? _____

Have you ever been diagnosed with a tumor, cancer, or neoplasia? No Yes. When? ____/____/____

Have you ever been diagnosed with diabetes? No Yes. When? ____/____/____

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure)?

No Yes. When? ____/____/____

Have you ever had a stroke or heart attack? No Yes. When? ____/____/____

Have you ever had a spinal cord injury? No Yes. When? ____/____/____

Have you ever had surgery on your neck? No Yes. When? ____/____/____

✓ Does anyone in your biological family (parent, grandparent, sibling, or child) have a history of:

Heart disease, stroke, cancer or diabetes? No Yes. Explain _____

Psychiatric diseases like depression, anxiety, schizophrenia, etc? No Yes. Explain _____

Neuropathies (nerve disease) or myopathies (muscle disease)? No Yes. Explain _____

Cancer? No Yes. Explain _____

Back or neck pain? No Yes. Explain _____

Any other known conditions? No Yes. Explain _____

✓ Patient Name: _____

Date of Birth: ____/____/____

Personal Health History, continued

✓ The following questions help us determine levels of stress. Please answer as completely as possible.

Please indicate your familial status Single Married Divorced Widowed Partnered
How many children do you have? None 1 2 3 4 Other: ____
Do you have a second job? _____ How many hours a week? _____
Describe your work environment: _____
Describe your home life: _____
What is your highest level of education? _____
What are your hobbies? _____

✓ Please answer the following questions as completely as possible. *Social history*

Quality of Life Rank. Please circle where you rate your current quality of life.

| Poor | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excellent |
|---|---|---|---|---|--|---|---|---|---|----|-----------|
| Has quality of life changed? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. Explain? _____ | | | | | | |
| Do you exercise? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. What type and how often? _____ | | | | | | |
| Do you currently use any tobacco products? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. What kind, how often and how long? _____ | | | | | | |
| Have you used tobacco products in the past? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. What kind, how long, and when did you quit? _____ | | | | | | |
| Do you drink alcoholic beverages? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. What kind and how many a week? _____ | | | | | | |
| Have you had issues with alcohol in the past? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. How long ago and for how long? _____ | | | | | | |
| Do you drink caffeinated beverages? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. What kind and how many a day? _____ | | | | | | |
| Do you currently use recreational drugs? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. What type, how often, and how long? _____ | | | | | | |
| Have you used recreational drugs in the past? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. What kind, how long, and for how long? _____ | | | | | | |
| Do you have any special dietary restrictions? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. What type? _____ | | | | | | |
| Are you sexually active? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. Have you ever been diagnosed with an STD or VD? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | |
| Do you currently see a chiropractor? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. When did you last see a chiropractor? _____ | | | | | | |

✓ **Quality of Sleep.** Please circle where you rate your current quality of life.

| Poor | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excellent |
|------------------------------|---|---|---|---|--|---|---|---|---|---|----|-----------|
| Can you fall asleep? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. How long? _____ | | | | | | | |
| Nightmares/Vivid dreams? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. | | | | | | | |
| Are you able to stay asleep? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. How many times do you wake up? _____ | | | | | | | |
| Night sweats? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. | | | | | | | |
| Restless leg at night? | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes. | | | | | | | |

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✓ **Headache.** Please circle where you rate your current quality of life.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain ever

Where do you feel the head pain? _____

Does the pain start at the neck and go up? _____

Have you identified triggers? No Yes. How many times per month _____

What aggravates the headache? _____

What makes it better? _____

Quality of Headache? Dull Fast Throbbing

Review of Systems & Medical History

✓ 1. Does anything trigger your symptoms such as exercise sleep posture environment? _____

✓ 2. Do your symptoms get worse with physical or mental activity? No Yes _____

✓ 3. Are you currently experiencing any of the following symptoms, now or recently?

- Chest pain
- Pale skin
- Neck Pain
- Shortness of breath
- Light-Headedness
- Swelling in your left arm
- Blackouts
- Left arm pain
- Jaw pain
- Excessive sweating without exertion

✓ 4. Please check off any of the below symptoms that you are experiencing now or recently.

- Nausea
- Difficulty with Swallowing
- Vomiting
- Dizziness or vertigo
- Abnormal sweating
- Difficulty with speaking
- Double vision
- Numbness
- feeling unsteady
- Blurred vision
- Balance problems
- Headache

✓ 5. Have you noticed any of the following?

- Recent fever
- Change in appetite
- Memory issues
- Unexplained weight loss
- Drowsiness
- Brain Fog
- Confusion
- Sensitivity Light
- Pressure in head
- Sensitivity to Sound
- Recent fatigue
- Unexplained weight gain
- More Emotional

✓ Patient Name: _____

Date of Birth: ____/____/____

Personal Health History, continued

✓ Please mark below any of the conditions that apply to you, past or present. Past Condition Present Condition

- | | | | | | | | | |
|-------------------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision | <input type="checkbox"/> | <input type="checkbox"/> | Panic attacks | <input type="checkbox"/> | <input type="checkbox"/> |
| Dislocated bones | <input type="checkbox"/> | <input type="checkbox"/> | Double vision | <input type="checkbox"/> | <input type="checkbox"/> | PTSD | <input type="checkbox"/> | <input type="checkbox"/> |
| Fractured bones | <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramping | <input type="checkbox"/> | <input type="checkbox"/> | OCD | <input type="checkbox"/> | <input type="checkbox"/> |
| Bone infection (osteomyelitis) | <input type="checkbox"/> | <input type="checkbox"/> | Tremors (shaking) | <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems or disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Herniated disc | <input type="checkbox"/> | <input type="checkbox"/> | Dyslexia | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty urinating | <input type="checkbox"/> | <input type="checkbox"/> |
| Scoliosis or other spinal curvature | <input type="checkbox"/> | <input type="checkbox"/> | Sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> | Feelings of urgency to urinate | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoarthritis or DJD | <input type="checkbox"/> | <input type="checkbox"/> | Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | Leg pain with walking | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Arrhythmia | <input type="checkbox"/> | <input type="checkbox"/> | Blood clots/phlebitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Other arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | Frequent colds or flus | <input type="checkbox"/> | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | <input type="checkbox"/> | Atherosclerosis/arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental or emotional disorder | <input type="checkbox"/> | <input type="checkbox"/> | Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Learning disability | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Feelings of suicide | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Gastric ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Infrequent urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart palpitations (heart racing) | <input type="checkbox"/> | <input type="checkbox"/> | Celiac Disease (Sprue) | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling in legs or feet | <input type="checkbox"/> | <input type="checkbox"/> | Irritable bowel syndrome | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive heart failure | <input type="checkbox"/> | <input type="checkbox"/> | Night sweats | <input type="checkbox"/> | <input type="checkbox"/> | Awaken to urinate | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic/frequent cough | <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis | <input type="checkbox"/> | <input type="checkbox"/> | Bladder infections | <input type="checkbox"/> | <input type="checkbox"/> |
| COPD | <input type="checkbox"/> | <input type="checkbox"/> | Skin cancer | <input type="checkbox"/> | <input type="checkbox"/> | Venous insufficiency | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | Loss of consciousness | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| Colon problems | <input type="checkbox"/> | <input type="checkbox"/> | Concussions | <input type="checkbox"/> | <input type="checkbox"/> | Other (please describe) | <input type="checkbox"/> | <input type="checkbox"/> |
| Gall bladder trouble | <input type="checkbox"/> | <input type="checkbox"/> | Weak muscles of face | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Stomach/duodenal ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Retinopathy | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Cirrhosis | <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Change in hat size | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Acne | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | Females only: | | |
| Trouble concentrating | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Is there any possibility that you are | | |
| Paralysis | <input type="checkbox"/> | <input type="checkbox"/> | Chrohn's disease | <input type="checkbox"/> | <input type="checkbox"/> | currently pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes | | |
| Twitching muscles | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | What was the date of your last | | |
| ADD or ADHD | <input type="checkbox"/> | <input type="checkbox"/> | Hyperthyroidism | <input type="checkbox"/> | <input type="checkbox"/> | menstrual period? | | |
| Macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> | Hypothyroidism | <input type="checkbox"/> | <input type="checkbox"/> | Date ____/____/____ | | |
| Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | Shingles | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Mouth sores | <input type="checkbox"/> | <input type="checkbox"/> | Warts | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Irregular heart beats | <input type="checkbox"/> | <input type="checkbox"/> | Psychological issues | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Experience passing out | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Skipped heart beats | <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Congenital heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Erectile dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Shortness of breath with activity | <input type="checkbox"/> | <input type="checkbox"/> | Discharge from urethra | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Short of breath at rest | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding disorder | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Polyps | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Diverticulitis | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Change in nails | <input type="checkbox"/> | <input type="checkbox"/> | Phobias | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Eczema | <input type="checkbox"/> | <input type="checkbox"/> | Breast discharge | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Dermatitis | <input type="checkbox"/> | <input type="checkbox"/> | Breast lumps/soreness | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Pain in your face | <input type="checkbox"/> | <input type="checkbox"/> | Vascular disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Temporal arteritis | <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Fainting spells | <input type="checkbox"/> | <input type="checkbox"/> | Auto immune disease | <input type="checkbox"/> | <input type="checkbox"/> | | | |

✓ Patient Name: _____

Date of Birth: ____/____/____

✓ Are there any other concerns or interests you have about your health that you would like us to address?

You may describe any other concerns or questions in this space:

✓ Patient Authorization

Thank you for taking the time to fill out this health history questionnaire. This information is important to the doctor obtaining an accurate clinical picture so as to make an appropriate diagnosis and treatment plan. Please sign below authorizing that the information in this form has been read and filled out completely and accurately to the best of your understanding. Also, understand that the information in this form is considered confidential and for use by your doctor at the Synergy Sports Wellness. Any disclosure is outlined in our privacy policies.

Patient's (or guardian's) signature

Date

Signature of translator or person assisting you
(if any)

Date

Printed name

⊖ Doctor's Notes. _____

Doctor's initials: _____