Synergy Spine and Nerve Center

Rio Rancho, NM 87124
505-891-2280

PATIENT INFORMATION

Today's date:	**Primary Care Physician:**

Patient's last name: First: Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid / Sig Other

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Birth date: / /	Age: Sex: ☐ M ☐ F

Street address:	Home phone no. : ( ) Cell phone no. : ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:

Chose clinic because / Referred to clinic by (please check one box):
☐ Dr. Referral ☐ newspaper ☐ Hospital ☐ Family/Friend ☐ TV ☐ Dinner Event ☐ Mailer ☐ Other

Email:	Spouse's Name:

Please List any other family members/friends involved in your health decisions:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient:	Home phone no. : ( )	Work phone no. : ( )

The above information is true to the best of my knowledge.
Patient/Guardian signature: *Date:*

(Please Print)

Personal History

Check all conditions that apply to you:

General	Neurological	Psychiatric	Respiratory
☐ Fatigue, tiredness ☐ Weakness ☐ Chills ☐ Fever ☐ Night sweat ☐ Appetite change ☐ Lived in foreign country ☐ Unexplained weight loss ☐ Unexplained weight gain ☐ Generalized pain ☐ Unable to tolerate heat ☐ Unable to tolerate cold ☐ Sedentary lifestyle ☐ Active lifestyle ☐ Other _____	☐ Fainting spells ☐ Seizures ☐ Paralysis ☐ Dizziness ☐ Tremor ☐ Chronic headaches ☐ Poor balance ☐ Fractured back or neck ☐ Numbness of face / arm / leg ☐ Peripheral neuropathy ☐ Stroke or Mini – stroke ☐ Other _____	☐ Depression ☐ Anxiety (abnormal) ☐ Panic attacks ☐ Alzheimer's ☐ Confusion (abnormal) ☐ Hospitalized for nervousness ☐ Substance abuse ☐ Anorexia ☐ Other _____	☐ Chronic obstructive disease ☐ Wheezing ☐ Chronic cough ☐ Coughing up blood ☐ Asthma ☐ Shortness of breath ☐ TB ☐ Lung Cancer ☐ Emphysema ☐ Chronic bronchitis ☐ Pneumonia ☐ Fluid in lungs ☐ Need to sleep sitting up ☐ Other_____
Cardiac	**Vascular**	**Gastrointestinal**	**Genitourinary**

☐ Angina (chest pain)
☐ Rapid heartbeat
☐ Past heart attacks
☐ Heart murmur
☐ Congestive heart failure
☐ High blood pressure
☐ Aortic aneurysm
☐ Other heart problem
☐ **Pacemaker**
☐ **Defibrillator**
☐ Other_____
	☐ Leg pain walking over 1 block
	☐ Leg pain walking less than 1 block
	☐ Pain in legs while at rest
	☐ Blood clots in legs
	  ☐ Deep
	  ☐ Superficial
	☐ Cold feet or hands
	☐ Amputation of toes
	☐ Amputation of feet or legs
	☐ Peripheral vascular disease
	☐ Ulcers of lower legs
	☐ Varicose viens
	☐ Aneurysm of arteries
	☐ Other _____
		☐ Diarrhea
		☐ Constipation
		☐ Stool changes
		☐ Bowel habits changes
		☐ Hemorrhoids
		☐ Indigestion
		☐ Ulcers
		☐ Irritable bowel
		☐ Colon polyps
		☐ Cramps/ pains
		☐ Cancer of the stomach or bowel
		☐ Diverticulitis
		☐ Other _____
			☐ Hesitancy / urgency of urine
			☐ Need to urinate often at night
			☐ Loss of bladder control
			☐ Difficult urination
			☐ Renal failure
			☐ Impotence
			☐ Current Dialysis
			☐ Renal transplant
			☐ Prostate enlargement
			☐ Cancer of bladder/ kidneys
			☐ Other
			_____

Blood & Lymph System	**Eyes, Ears, Nose & Throat**	**Musculoskeletal**	**Skin**
☐ Anemia ☐ Blood disease ☐ Transfusions ☐ Leukemia ☐ Bone marrow test ☐ Long term Coumadin use ☐ Blood clotting problems ☐ Other _____	☐ Pain ☐ Hearing loss ☐ Polyps ☐ Vertigo ☐ Ringing in ears (tinnitus) ☐ Sinus infections ☐ Deafness ☐ Other _____	☐ Arthritis ☐ Joint swelling ☐ Joint stiffness ☐ Muscle aches ☐ Muscle weakness ☐ Leg cramps ☐ Other _____	☐ Rashes ☐ Tumors ☐ Sensitivity to sunlight ☐ Malignant melanoma ☐ Squamous cell carcinoma ☐ Basal cell carcinoma ☐ Easy bruising ☐ Fungal infections ☐ Non-healing sores ☐ Excessive rough or dry skin ☐ Other _____
Endocrine	**IF Diabetic**	**Abnormal Organs**	
☐ Thyroid problems ☐ **Diabetes – Type 1** ☐ **Diabetes – Type 2**	Avg blood sugar in the AM _____ Last A1c result _____	☐ Hepatitis ☐ Cirrhosis (Liver) ☐ Gallbladder disease	Height: _____ Weight: _____

Nutritional Habits

IT IS IMPORTANT TO ANSWER THESE QUESTIONS AS HONESTLY AS POSSIBLE. YOUR ASNWERS ARE NOT A JUDGEMNT OF YOU. THE GOAL IS TO IDENTIFY AREAS THAT CAN BE FOCUSED ON TO IMPROVE YOUR WELL BEING AND QUALITY OF LIFE

On a scale of 1-10 how would you rate the overall quality of your nutritional habits?

1 2 3 4 5 6 7 8 9 10

On a scale of 1-10 how much attention and mindfulness do you give to your nutrition?

1 2 3 4 5 6 7 8 9 10

How fast do you eat?

- ☐ Very fast, food is gone before you know it and I am finished before anyone else
- ☐ Moderate, I finish my food about the same time as most others
- ☐ Slow, I take my time and usually I am still eating when most others are done

Do you think you eat:

O Too much, I need to eat less O About right O Not enough, I could eat more

How much sugar do you eat?

O A lot O More than I should O Some O Very Little O None

How many veggies and fruits do you get MOST DAYS?

O 5-8 servings O 3-4 servings O1-2 servings O None

What is your approach to carbs?

O Avoid them OFocus on the right type O Try to limit

What is your approach to fats?

O Don't think about fats O Try to get quality fats in my diet O Avoid fats

What is your biggest nutritional challenge?

If you could improve just ONE thing about your nutrition, what would that be that would have the BIGGEST impact on your health?

Physical Activity Habits

IT IS IMPORTANT TO ANSWER THESE QUESTIONS AS HONESTLY AS POSSIBLE. YOUR ASNWERS ARE NOT A JUDGEMNT OF YOU. THE GOAL IS TO IDENTIFY AREAS THAT CAN BE FOCUSED ON TO IMPROVE YOUR WELL BEING AND QUALITY OF LIFE

How physically active are you?

O Very O Moderately O Slightly O Not at all

What types of activities do you engage in on a weekly basis?

O Walking O Running O Cycling O Swimming

OYoga O Strength training O Other _____

How many times per week do you purposefully engage in physical activity that raises your heart rate?

O None O 1-2 O 3-4 O 5-7

How much total time per week do you engage in physical activity per week on average?

_____ minutes

What are the physical activities you ENJOY doing the most:

#1 _____ #2 _____ #3 _____

Medications – Please list all medications and supplements you are currently taking

Name	Dosage	Name	Dosage

If you need additional space, Please use the back of this page.

Are you currently receiving chiropractic care? O Yes O No

If so, by whom? _____ When was your last visit? _____

What is your major complaint that brought you to our clinic?

_____

_____

_____

How long have you had this problem?

_____

_____

Before you began having this problem was there an earlier condition, accident, or injury that could have brought this problem about? ☐ Yes ☐ No If so please describe:

_____

_____

_____

What have you tried for treatment that did not work?

_____

_____

Have you seen a M.D. , P.T. , or a D.C. for this problem? Yes No

Doctor's Name	Specialty	Year(s) Seen

How does this problem interfere with your daily day life?

_____

_____

_____

Have you been worried about getting this problem resolved?

☐ Yes ☐ No If yes, please describe:

_____

_____

_____

What is your main concern about your symptoms?

_____

_____

_____

On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

	0	1	2	3	4	5	6	7	8	9	10