



**Synergy**  
Wellness Center

## Patient Information

Date \_\_\_\_\_  
 Patient Name \_\_\_\_\_  
 What do you prefer to be called? \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Gender M F Birth date \_\_\_\_\_ Age \_\_\_\_\_  
 Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
 Relationship Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_  
 Domestic Partnership \_\_\_\_\_ Widowed \_\_\_\_\_ Other \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_  
 May we consult your doctor regarding your care in our office? Y N  
**E-mail** \_\_\_\_\_



## Contacts

Home Phone (\_\_\_\_) \_\_\_\_\_  
 Cell Phone (\_\_\_\_) \_\_\_\_\_  
 Work Phone (\_\_\_\_) \_\_\_\_\_

Best number to reach you during business hours:  
 \_\_\_\_Home \_\_\_\_Cell \_\_\_\_Work

Who may we thank for referring you?  
 \_\_\_\_\_

\_\_\_\_Internet \_\_\_\_Yellow Pages \_\_\_\_Walk-in \_\_\_\_Newspaper

### In Case of Emergency, contact:

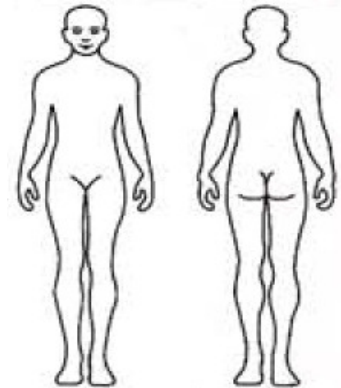
Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Phone number(s) \_\_\_\_\_



## Patient Condition/Accident Information

Reason for visit \_\_\_\_\_  
 When did your symptoms appear? \_\_\_\_\_  
 Is this condition due to an accident? Y N Date of accident \_\_\_\_\_  
 What type of accident? Auto \_\_\_\_\_ Work \_\_\_\_\_ Home \_\_\_\_\_ Other \_\_\_\_\_  
 Is this condition getting progressively worse? Y \_\_\_\_\_ N \_\_\_\_\_ Unknown \_\_\_\_\_  
 Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) \_\_\_\_\_  
 Type of pain: Sharp \_\_\_\_ Dull \_\_\_\_ Throbbing \_\_\_\_ Numbness \_\_\_\_ Aching \_\_\_\_ Shooting \_\_\_\_  
 Burning \_\_\_\_ Tingling \_\_\_\_ Cramps \_\_\_\_ Stiffness \_\_\_\_ Swelling \_\_\_\_ Other \_\_\_\_\_  
 How often do you have this pain? \_\_\_\_\_  
 Is it constant or does it come and go? \_\_\_\_\_  
 Does it interfere with your: Work \_\_\_\_\_ Sleep \_\_\_\_\_ Daily Routine \_\_\_\_\_ Recreation \_\_\_\_\_  
 Activities or movements that are painful to perform:  
 Sitting \_\_\_\_\_ Standing \_\_\_\_\_ Walking \_\_\_\_\_ Bending \_\_\_\_\_ Lying Down \_\_\_\_\_

Please mark an X on the picture where you continue to have pain, numbness, or tingling.



## Insurance Information

Who is responsible for this account? \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Is patient covered by additional insurance? Y N  
 Subscriber's Name \_\_\_\_\_  
 Birth date \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Group # \_\_\_\_\_

### Assignment and Release:

I certify that I, and /or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insured benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above- named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

### Signature of Patient, guardian, or personal representative:

\_\_\_\_\_  
 Printed Name \_\_\_\_\_  
 Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_





# Health History

Please indicate your use/intake of the following:

			Amount (per day)
Water intake	Y	N	_____
Sodas	Y	N	_____
Recreational Drugs	Y	N	_____
Alcohol	Y	N	_____
Coffee/Black Tea	Y	N	_____
Tobacco	Y	N	_____

Injuries/Surgeries you have had:

	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Car Accidents	_____	_____

Exercise: \_\_\_ None \_\_\_ 1X/MONTH \_\_\_ 1X/WK \_\_\_ 2-3X/WK \_\_\_ 4X +/WK

Work Activity: \_\_\_ Sitting \_\_\_ Standing \_\_\_ Light Labor \_\_\_ Heavy Labor \_\_\_ Other \_\_\_\_\_

Stress Level: \_\_\_ Low \_\_\_ Moderate \_\_\_ High Sources of Stress \_\_\_\_\_

What activities, if any, do you participate in to reduce your stress levels? \_\_\_\_\_

Are you pregnant? Y N Due Date \_\_\_\_\_

Have you ever had a lapse of memory? Y N When? \_\_\_\_\_

Were you ever knocked unconscious? Y N When? \_\_\_\_\_

How many hours per day do you use a computer? \_\_\_\_\_

How many hours of quality sleep do you get each night? \_\_\_\_\_



# Symptom Survey

Please CIRCLE to indicate if you currently HAVE & underline if you have HAD any of the following:

If current, indicate how often you experience that symptom.

Lack of appetite	Excessive talking	Eye problems
Excessive appetite	Inappropriate laughter	Jaundice
Loose stool	Chest pain	Easily angered/irritated
Blood in stools	Abdominal pain	Difficulty making decisions
Diarrhea	Sciatic pain	Soft or brittle nails
Indigestion	Coughing	Muscle spasms/twitching
Vomiting/Nausea	Shortness of breath	Dizziness/vertigo
Belching/Burping	Poor sense of smell	Low back pain
Heartburn/Acid reflux	Sinus/nasal problems	Knee problems
Bloating	Tightness in the chest	Poor hearing
Food retained in stomach	Skin rashes	ringing in ears
Depression	Dry skin	Hair loss
Fatigue	Severe acne	Kidney stones
Obsessive tendencies	Pain or coldness in genitals	Urinary difficulty
Insomnia	Hemorrhoids	Edema
Heart palpitations	Black/tarry stool	Other _____
Cold hands and feet	Diverticulitis	Other _____
Nightmares	Gallstones	Other _____
Anxiety	Difficulty digesting oily food	
Mentally restless	Light colored stool	



# ACUPUNCTURE PATIENTS ONLY

Have you received acupuncture or Chinese herbal therapy before? Y N If so, how long ago? \_\_\_\_\_

With whom? \_\_\_\_\_ For what reason? \_\_\_\_\_

### Please answer the following questions:

Are you easily bruised? Y N

Do you tend to catch colds or the flu easily? Y N

Are you intolerant to weather changes? Y N

Have you experienced a sudden, significant weight gain or loss? Y N ...if yes, \_\_\_ gain \_\_\_ loss

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments
Significant other						
Family						
Diet						
Sex						
Self						
Work						
Spirituality						

What are the main health concerns for which you are seeking treatment? \_\_\_\_\_

What other forms of treatment have you used? \_\_\_\_\_

List any other health concerns you currently have: \_\_\_\_\_

## Reproductive History

Sexually Transmitted Diseases: \_\_\_ Gonorrhea \_\_\_ Syphilis \_\_\_ AIDS \_\_\_ HPV \_\_\_ Chlamydia \_\_\_ Herpes Dates: \_\_\_\_\_

Color of urine: \_\_\_\_\_ Clear \_\_\_ Murky \_\_\_ Odor

### Women:

#### Menses:

Age of 1<sup>st</sup> period (menarche) \_\_\_\_\_

Age of final period (Menopause) \_\_\_\_\_

# of days between periods \_\_\_\_\_

# of days of flow \_\_\_\_\_

Color of flow \_\_\_\_\_

Clots? Y N Color: \_\_\_\_\_

#### Pregnancies:

# of pregnancies \_\_\_\_\_

# of live births \_\_\_\_\_

# of multiple births \_\_\_\_\_

# of miscarriages \_\_\_\_\_

# of abortions \_\_\_\_\_

#### Exams/Results:

Date of last GYN exam: \_\_\_\_\_

Date of last PAP smear: \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_

Date of last bone density exam: \_\_\_\_\_

Results: \_\_\_\_\_

Have you been diagnosed with: \_\_\_ Fibroids \_\_\_ Fibrocystic Breasts \_\_\_ Endometriosis \_\_\_ Ovarian Cysts \_\_\_ PID

\_\_\_ Breast Cancer \_\_\_ Ovarian Cancer \_\_\_ Interstitial Cystitis \_\_\_ Frequent UTI's \_\_\_ Other \_\_\_\_\_

Location of Menstrual Discomfort: \_\_\_ Lower abdomen \_\_\_ Lower back \_\_\_ Thighs

Nature of Discomfort: \_\_\_ Cramping \_\_\_ Stabbing \_\_\_ Burning \_\_\_ Aching \_\_\_ Dull \_\_\_ Bloating

\_\_\_ Consistent \_\_\_ Intermittent \_\_\_ Bearing-down sensation

Timing of Discomfort: \_\_\_ Before Menses \_\_\_ During Menses \_\_\_ After Menses

Menstrual & Premenopausal Symptoms: \_\_\_ Discharge \_\_\_ Nausea \_\_\_ Swollen Breasts \_\_\_ Excessive appetite \_\_\_ Headache

\_\_\_ Increased libido \_\_\_ Urinary Incontinence \_\_\_ Vaginal dryness \_\_\_ Constipation \_\_\_ Mood swings \_\_\_ Diarrhea

\_\_\_ Decreased libido \_\_\_ Poor appetite \_\_\_ Insomnia \_\_\_ Night sweats \_\_\_ Hot flashes \_\_\_ Other \_\_\_\_\_

### Men:

Reproductive and prostate related symptoms: \_\_\_ Delayed Stream \_\_\_ Dribbling \_\_\_ Urinary Incontinence \_\_\_ Retention of urine

\_\_\_ Rectal dysfunction \_\_\_ Increased libido \_\_\_ Decreased libido \_\_\_ Premature ejaculation \_\_\_ Impotence

\_\_\_ Groin pain \_\_\_ Testicular pain \_\_\_ Penile discharge \_\_\_ Back pain

Date of last prostate exam: \_\_\_\_\_ PSA results: \_\_\_\_\_ Prostate exam results: \_\_\_\_\_

Have you been diagnosed with: \_\_\_ Inguinal Hernia \_\_\_ Erectile Dysfunction \_\_\_ Low sperm count \_\_\_ Prostate Cancer

\_\_\_ Testicular Cancer \_\_\_ Un-descended Testis \_\_\_ Other \_\_\_\_\_