CYNERGY
HEALTH & WELLNESS

We are the community resource center for optimal health and healing.

Patient Application Form

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if your case is one we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Name _____ Date _____ S.S.# _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell# _____ E-Mail _____

Marital Status: S / M / D / W Spouse's Name _____

Occupation: _____ Your Employer: _____

Business Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to us? _____

Emergency Contact _____ Phone # _____ Relation _____

Who is your primary care physician? _____

Insurance Information:

If you have any insurance information please provide the staff with your insurance card and/or necessary forms. Thank you.

Purpose of This Visit

Reason for this visit: _____

Is your visit related to an accident or work injury? ❑ Yes ❑ No If Yes, please indicate the date of accident/injury: _____

Briefly describe the accident/injury: _____

Please describe the pain and its location:_____

When did this condition begin? _____

Is the condition: ❑ Constant ❑ Often ❑ Activity related

When did this problem start? ❑ Gradually ❑ Suddenly ❑ Progressively

Is your problem? ❑ Getting worse ❑ Getting better ❑ Staying the same

What increases your pain? _____ What decreases your pain? _____

Have you ever experienced this problem before? ❑ Yes ❑ No
If Yes, please explain: _____

Is this condition affecting your work or social life? ❑ Yes ❑ No
If Yes, please explain: _____

Please list any other complaints currently bothering you:_____

Please list any prescription medications you are currently taking:_____

Experience with Chiropractic

Have you seen a Chiropractor before? ❑ Yes ❑ No

Who? _____ When? _____

Reason for your previous visits:_____How did you respond to treatment?_____

Did your previous Chiropractor take x-rays before you began treatment? ❑ Yes ❑ No

After treatment? ❑ Yes ❑ No

Have you been told that you have a spinal curvature or spinal arthritis? ❑ Yes ❑ No

Spinal misalignments can cause premature aging which results in grinding or cracking.
Do you ever hear noises when you move your head or back? ❑ Yes ❑ No

Health & Posture Review

Abnormal postural habits or distortions are the result of trauma or stress to the body that have caused a shift in the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae.

The latest research shows that these misalignments and distortions will weaken the overall structure of your spine thereby causing stress to your nervous system. The most common and detrimental postural distortion is called **Forward Head Posture**.

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture? Poor 1 2 3 4 5 6 7 8 9 10 Excellent

Are you aware of any poor posture habits? ❑ Yes ❑ No

If Yes, explain: _____

Neck

Postural Distortions in your neck will weaken the nerves in your arms, hands, and head affecting the parts of your body listed below. Please check all conditions that apply to you:

❑ Neck pain
❑ Pain in the shoulders/arms/hands
❑ Tingling & Numbness
❑ Recurrent cold/flu
❑ Headaches
❑ Dizziness
❑ Visual Disturbances
❑ Coldness in hands
❑ Sinusitis
❑ Allergies
❑ Low Energy
❑ TMJ Pain

Mid and Upper Back

Postural Distortions in your mid and upper back can weaken the nerves into your ribcage, chest, and digestive tract which can affect the parts of your body listed below. Please check all conditions that apply to you:

❑ Upper/Mid back pain
❑ Pain into your ribs or chest
❑ Indigestion
❑ Gastric Reflux (GERD)
❑ Nausea
❑ Ulcers or Gastritis
❑ Hypoglycemia
❑ Irritability or feeling tired after eating

Low Back

Postural Distortions in the low back will weaken the nerves into your legs, feet, or pelvic region and can affect the parts of your body listed below. Please check all conditions that apply to you:

❑ Pain in the low back or pelvis
❑ Tingling or numbness in your legs/feet
❑ Recurrent bladder infections
❑ Muscle cramps in your legs/feet
❑ Weakness in your hips/knees/ankles
❑ Coldness in your legs/feet
❑ Menstrual cramping
❑ Constipation or Diarrhea

Please list any other health condition not mentioned above:_____

Lifestyle Information

Do you exercise? ❑ Yes ❑ No How often? _____

What type of exercise: _____

Do you smoke? ❑ Yes ❑ No Do you drink alcohol? ❑ Yes ❑ No How much/week? _____

Do you take any vitamins/supplements? If so, Please list below:

_____

What position do you sleep in (on back, side, stomach, etc.)? _____

How many hours per day do you spend at a computer? _____

Please list any medications that you are currently taking and why? _____

_____

_____

Authorization:

I certify that I have read and understand the above information to the best of my knowledge. The questions have been answered to the best of my ability. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information (including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care) to any third party payers and/or health care practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf.

Patient's Signature_____ Date _____