Dr. Andy Stynchula, D.C.

Confidential Health Information

Please allow our staff to photocopy your insurance details.
All information you supply is confidential. We comply with all federal privacy standards.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

◯No ◯Yes When?_____

Whom may we thank for referring you?

If so, whom?

Your Last Name, First Middle (or Initial) Social Security Number Birth Date (MM/DD?YY) Age

Address

Gender F/M

Race / Ethnicity

Marital Status ◯Married ◯Single ◯ Divorced ◯ Widowed ◯ Separated

City State Zip/ Postal Code

Preferred Language

Home Phone Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact Name Emergency Contact's Phone

Child's Name and Age

Your Occupation

Work Phone

Your Employer

May we contact you at work? Yes/ No

Address City State Zip Code

Preferred method of contact?
◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name, First Middle (or initial)

Birth Date (MM/DD/YYYY)

Who carries this policy?
◯ Self ◯ Spouse ◯ Parent

Insured's Employer

Employer's Phone

Address City State/Province Zip/ Postal Code

1. The symptom(s) that have prompted me to seek care today included:_____

(Continued from previous page)

2. And are the result(s) of (check circle): ○ Accident or injury
○ Work ○ Auto ○ Other _____
○ A worsening long-term problem
○ An interesting in: ○ Wellness ○ Other _____

3. Onset (When did you first notice your current symptom?): _____

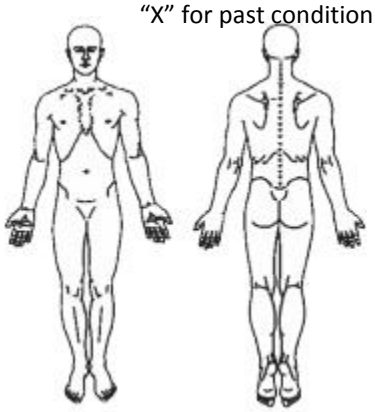
4. Intensity (How extreme are your current symptoms?):

0 O-O-O-O-O-O-O-O-O-O-O 10
Absent Uncomfortable Agonizing

5. Duration & Timing (When did it start & how often do you feel it?)
○ Constant ○ Comes and goes. How often? _____
_____

6. Quality of symptoms (what does it feel like?)
O Numbness
O Tingling
O Stiffness
O Dull
O Aching
O Cramps
O Nagging
O Sharp
O Burning
O Shooting
O Throbbing
O Stabbing
O Other:
_____

7. Location (where does it hurt?)
"0" for current condition
"X" for past condition



8. Radiation: (Does it affect other areas of your body? To what area does the pain radiate, shoot or travel?)
_____

9. Aggravating/ relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc…)
What tends to worsen the problem? _____
_____
What tends to lessen the problem? _____
_____

10. Prior Intervention (What have you done to relieve the symptoms?)

○ Prescription medication	○ Surgery	○ Ice/Heat
○ Over-the-counter drugs	○ Acupuncture	○ Homeopathic remedies
○ Chiropractic	○ Massage	○ Physical Therapy
○ Other _____		

11. What else should Dr. Andy knows about your current condition? _____
_____

12. How does your current condition interfere with your:
Work/ career: _____
Recreational activities: _____
Household responsibilities: _____
Personal relationship: _____

13. Review of Systems: Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Osteoporosis	O	O	Arthritis	O	O	Scoliosis	O	O	Neck pain	O	O	Back problems	O	O	Hip disorders
O	O	Knee injuries	O	O	Foot/ankle pain	O	O	Shoulder problems	O	O	Elbow/wrist pain	O	O	TMJ issues	O	O	Poor posture

b. Neurological

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Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Anxiety	O	O	Depression	O	O	Headache	O	O	Dizziness	O	O	Pins & needles	O	O	Numbness

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	High blood Pressure	O	O	Low blood pressure	O	O	High cholesterol	O	O	Poor circulation	O	O	Angina	O	O	Exercise bruising

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Asthma	O	O	Apnea	O	O	Emphysema	O	O	Hay fever	O	O	Shortness of breath	O	O	Pneumonia

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Anorexia/ Bulimia	O	O	Ulcer	O	O	Food sensitivities	O	O	Heartburn	O	O	Constipation	O	O	Diarrhea

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Blurred vision	O	O	Ringing in ears	O	O	Hearing loss	O	O	Chronic ear infection	O	O	Loss of smell	O	O	Loss of taste

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Skin cancer	O	O	Psoriasis	O	O	Eczema	O	O	Acne	O	O	Hair Loss	O	O	Rash

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Thyroid issues	O	O	Immune disorder	O	O	Hypoglycemia	O	O	Frequent infection	O	O	Swollen glands	O	O	Low energy

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Kidney stones	O	O	Infertility	O	O	Bedwetting	O	O	Prostate issues	O	O	Erectile Dysfunction	O	O	PMS symptom

j. Constituional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
O	O	Fainting	O	O	Low libido	O	O	Fatigue	O	O	Sudden weight gain/loss(circle one)	O	O	Poor appetite	O	O	Weakness

14. Past Personal History (Please identify your past health history, including accidents, injuries, illnesses & treatments):

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
O	O	AIDS	O	O	Tuberculosis
O	O	Alcoholism	O	O	Typhoid fever
O	O	Arteriosclerosis	O	O	Ulcer
O	O	Cancer	O	O	Other_____
O	O	Chicken pox			
O	O	Diabetes			
O	O	Epilepsy			
O	O	Glaucoma			
O	O	Goiter			
O	O	Gout			
O	O	HIV positive			
O	O	Hepatitis			
O	O	Heart disease			
O	O	Malaria			
O	O	Measles			
O	O	Multiple Sclerosis			
O	O	Mumps			
O	O	Polio			
O	O	Hepatitis			
O	O	Rheumatic fever			

15. Operation

Surgical interventions, which may or maybe have included hospitalization.

- O Appendix removal
- O Bypass surgery
- O Cancer
- O Cosmetic surgery
- O Elective surgery:_____
- O Eye surgery
- O Hysterectomy
- O Pacemaker
- O Spine:_____
- O Tonsillectomy
- O Vasectomy
- O Other: _____

_____

(Continued from previous page)

O O Scarlet fever
O O Sexually transmitted disease
O O Stroke

16. Treatments (Check the ones you've received in the **Past** or are receiving **Currently**):

Past	Currently		Past	Currently	
O	O	Acupuncture	O	O	Homeopathy
O	O	Antibiotic	O	O	Hormone replacement
O	O	Birth control pills	O	O	Intaker
O	O	Blood transfusion	O	O	Massage therapy
O	O	Chemotherapy	O	O	Physical therapy
O	O	Chiropractic care	O	O	Nutritional supplements (list): _____
O	O	Dialysis	O	O	Medications (prescription and over-the-counter): _____
O	O	Herbs			_____

17. Injuries (have you ever…):

O Had a fractured or broken bone
O Used a crutch or other support
O Had a spine or nerve disorder
O Used neck or back bracing
O Been knocked unconscious
O Received a tattoo
O Been injured in an accident
O Had a body piercing

18. Family History (Some health issues are hereditary. Tell Dr. Andy about the health of your immediate family members):

Relative:	**Age (if living)**	**State of Health (circle)**	**Illnesses & Age of death**	**Causes of death**
Mother	_____	Good Bad	_____	Natural Illness
Father	_____	Good Bad	_____	Natural Illness
Sister 1	_____	Good Bad	_____	Natural Illness
Sister2	_____	Good Bad	_____	Natural Illness
Brother 1	_____	Good Bad	_____	Natural Illness
Brother 2	_____	Good Bad	_____	Natural Illness

19. Are there any other hereditary health issues that you know about? _____

_____

20. Social History (Tell Dr. Andy about your health habits and stress levels):

Alcohol use	O Daily	O Weekly	How much?	_____
Coffee use	O Daily	O Weekly	How much?	_____
Tobacco use	O Daily	O Weekly	How much?	_____
Exercising	O Daily	O Weekly	How much?	_____
Pain relievers	O Daily	O Weekly	How much?	_____
Soft drinks	O Daily	O Weekly	How much?	_____
Water intake	O Daily	O Weekly	How much?	_____

Prayer or mediation? Yes / No
Job Pressure/stress? Yes / No
Financial peace? Yes / No
Vaccinated? Yes / No
Mercury fillings? Yes / No
Recreational drugs Yes / No

Hobbies: _____

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate	Severe Effect
Sitting	O	O	O	O
Rising out of chair	O	O	O	O
Standing	O	O	O	O
Walking	O	O	O	O

	No Effect	Mild Effect	Moderate	Severe
Grocery shopping	O	O	O	O
Household chores	O	O	O	O
Lifting objects	O	O	O	O
Reaching overhead	O	O	O	O

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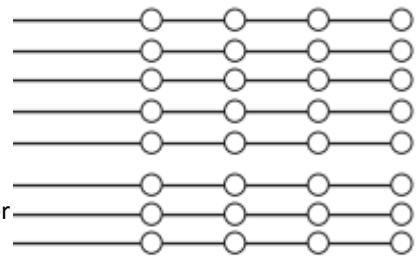
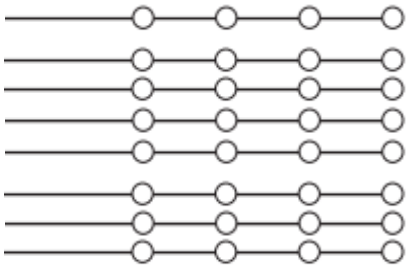
Lying down
Bending over
Climbing stairs
Using a computer
Getting in/out of car
Driving a car
Looking over shoulder
Caring for family



Showering or bathing
Dressing myself
Love life
Getting to sleep
Staying asleep
Concentrating
Exercising
Yard work



22. What is the major stress in your life? _____

23. How much sleep do you average per night? _____ (Hours)

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habit: O Skipped breakfast O 2 meals a day O 3 meals a day O Snacking between meals

27. What would be the most significant thing that could do to improve your health? _____

_____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements:

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initial: _____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxations. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initial: _____ I may request a copy of the Informed Consent and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initial: _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initial: _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to be as an extension of my care in this office.

Initial: _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initial: _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.

If the patient is a minor child, print child's full name: _____

_____ _____

Signature Date (MM/DD/YYYY)