

Synergy Medical Centers, LLC

HEALTH SURVEY

PLEASE COMPLETE THE FOLLOWING

Name: _____ Date of Birth: ___/___/___ Home Phone: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ # Hours/Week Currently Working: _____
Spouse's Occupation: _____ # Hours/Week Currently Working: _____
E-mail Address: _____ Cell Phone: _____

Check off any of the following symptoms you have experienced in the past 6 months—even if minor:

- | | | |
|---|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Tired During the Day |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Numbing/Tingling in Arms/Hands | <input type="checkbox"/> Have you had a weight problem |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Have you tried to lose weight |
| <input type="checkbox"/> Headaches/Tension | <input type="checkbox"/> Numbing/Tingling in Legs/Feet | <input type="checkbox"/> Are you interested in losing weight |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervous and Stressed | <input type="checkbox"/> Have tried medical weight loss |

OTHER (explain) _____

Which of the above is the worst? _____

How long have you had it? _____

What activities would you like to do if this was not a problem? _____

Does this affect your work?

- Decision making
- Poor attitude
- Decreased productivity
- Exhausted at the end of the day

Does this affect your life?

- Lose patience with spouse/children
- Restricted household duties
- Hinders ability to exercise or sports
- Interferes with ability to do hobbies

What have you tried to help relieve/get rid of this problem and how much did it help? (Circle All Appropriate)

- | | | | | | | | |
|----------------------------|--------|------|------|----------------------|--------|------|------|
| ◆ Medications Helped: | Little | Some | Much | ◆ Exercise Helped: | Little | Some | Much |
| ◆ Physical Therapy Helped: | Little | Some | Much | ◆ Nutrition Helped: | Little | Some | Much |
| ◆ Chiropractic Helped: | Little | Some | Much | ◆ Stretching Helped: | Little | Some | Much |

On a scale of "1" to "10", "1" is no commitment, you will live with your problem(s) the way it is now, to a "10", which is, you will do whatever it takes to get rid of your problem and improve your life. Please rate your commitment to getting rid of your problem: _____ →

I consent to receiving a health screening. I realize I am not receiving a diagnosis, treatment or prognosis for any condition I may be experiencing. I acknowledge I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: _____ Date: ___/___/___

Appointment date: _____ Appointment time: _____ Made by & Where: _____

Is there any insurance you would like us to verify for future visits? Yes [] No []

Ins. Co. _____ Policy & Group Nos. _____ Ins Co. Tel No. _____