



It's been a while since we've seen you...

Name: _____ Date: _____

Current Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Telephone #: (h) _____ (c) _____ (w) _____

Employer Name and Address: _____

Marital Status: Married Single Divorced Widowed Partner

Spouse's Name: _____

Primary Care Physician: _____

In order for the doctor's to best treat you, they must have all current information about your present health status. To bring your file up to date, please provide us with the following information. THANK YOU ©

1. My present symptoms are: _____

2. Is this injury a result of a motor vehicle or work accident? yes no

3. Recent surgeries, with date: _____

4. Recent accidents or falls: _____

5. Last Adjustment: _____

6. Last Physical: _____

7. Since I last saw you, I have seen the following other doctors (MD or Chiropractor):

8. Anything else you would like the doctor to know? _____

.....
Patient/Guardian Signature: _____

Name of insurance: _____ ID#: _____

Insured's name: _____ Relationship: _____

Michael Troknya, D.C. * Kristin Rayball, D.C.

340 Post Road, Fairfield, CT 06824 * www.physicalsynergy.com * Phone: 203-259-3210

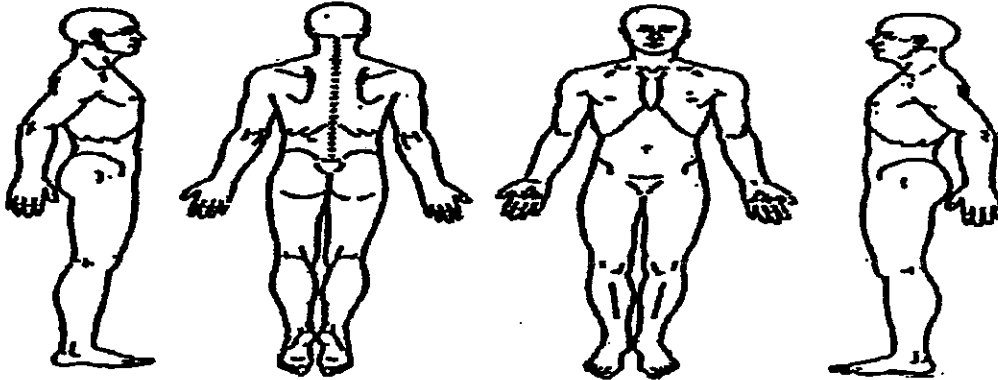


PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation Major Medical Case

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- Constantly (76-100% of the time) Occasionally (26-50% of the time)
 Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric like with motion
 Stiff Other: _____

5. How are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

13a. What alleviates your problem?

14. What concerns you the most about your problem?

15. What is your: Height _____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

- | Past | Present | Past | Present | Past | Present |
|--------------------------|---|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Smoking/Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> Angina | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Weight Gain/Loss | | |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite | | |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> | For Females Only |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Ulcer | <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Hormonal Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> General Fatigue | | |
| <input type="checkbox"/> | <input type="checkbox"/> Tumor | <input type="checkbox"/> | <input type="checkbox"/> Muscular Incoordination | | |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances | | |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> Dizziness | | |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____ | | | | |

20. List all prescription and over-the-counter medications you are currently taking:

21. List all of the supplements you are currently taking:

22. List all surgical procedures you have had:

23. What activities do you do at work?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |

24. What activities do you do outside of work?

25. Have you ever been hospitalized? No Yes

if yes, why _____

26. Have you ever see a Chiropractor before? No Yes

if yes, when and for what _____

27. Have you had significant past trauma? No Yes

28. Anything else pertinent to your visit today? _____

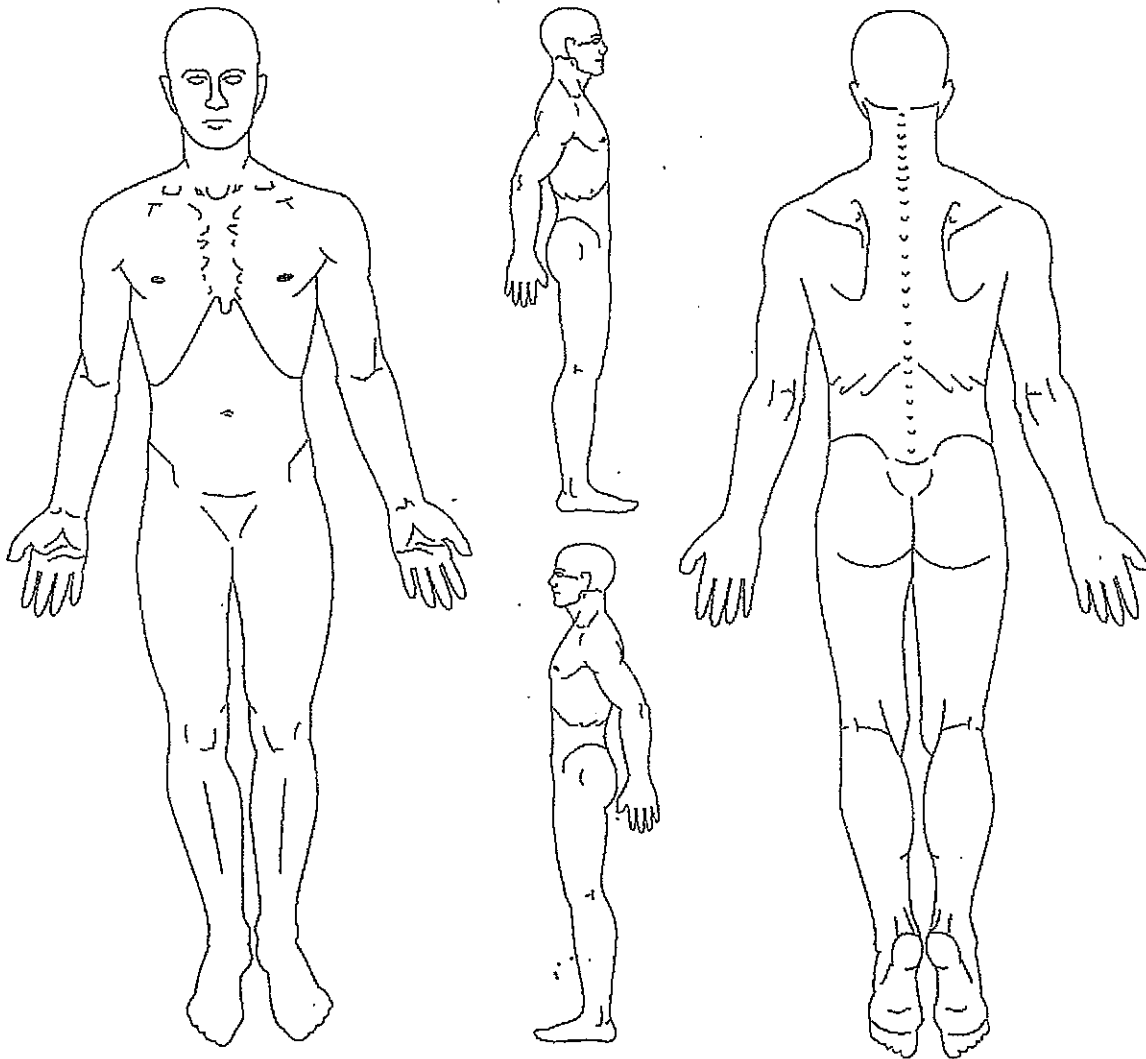
Patient Signature _____ Date: _____

Patient Name(Print) _____ Date _____

Patient ID # _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

- D** = Dull
- B** = Burning
- N** = Numb
- S** = Stabbing/Cutting
- T** = Tingling (Pins & Needles)
- C** = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now**:

Rate your pain at its **best** in the past week:

No Pain

Unbearable Pain

No Pain

Unbearable Pain



Rate your **average** pain in the past week:

Rate your **worst** pain in the past week:

No Pain

Unbearable Pain

No Pain

Unbearable Pain



Overall Functional Health Assessment

What is functional health?

At Physical Synergy, we are dedicated to helping each and every patient obtain their maximum level of functional health. Functional Health is your ability to perform your day to day tasks and activities as well as your leisure and recreational activities without discomfort and to the best of your ability.

For example, do you find yourself walking down the stairs on an angle because your knees bother you, or avoid getting down on the floor to play with your kids because your back hurts when you try and get up.

Take a moment and think about how your current level of pain/discomfort affects your ability to live your life each day. Now, think back one, and even five years ago to your ability to get the most out of each day, and compare that to today.

Average Functional Health this Week	Average Functional Health 1 year ago
<div style="display: flex; justify-content: space-between; font-size: small;"> Poor Optimal </div> <div style="border-top: 1px solid black; height: 20px; margin-top: 5px;"></div>	<div style="display: flex; justify-content: space-between; font-size: small;"> Poor Optimal </div> <div style="border-top: 1px solid black; height: 20px; margin-top: 5px;"></div>
Functional Health Today	Desired Functional Health
<div style="display: flex; justify-content: space-between; font-size: small;"> Poor Optimal </div> <div style="border-top: 1px solid black; height: 20px; margin-top: 5px;"></div>	<div style="display: flex; justify-content: space-between; font-size: small;"> Poor Optimal </div> <div style="border-top: 1px solid black; height: 20px; margin-top: 5px;"></div>

To be filled in by the Doctor

Treatment Plan

Treatment type	Frequency and duration
Adjustment	
Rehab/Physical Therapy	
Manual Therapy	
Graston Technique	
JTECH	
Nutrition	
Other	
Re-exam in: 3 4 6 8 visits OR 1 2 3 4 weeks OTHER:	
Dr. Signature:	