Synergistic Healthcare, PLLC
1100 N San Francisco Street, Ste A,
Flagstaff, AZ 86001

Synergistic Healthcare Adult Intake

How did you hear about us (please be specific)? ____________________

Context of Care Review

Successful heath care and preventive medicine are only possible when the physician has a complete understanding if the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your, time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

What three expectations do you have from this visit, and/or what are your most important health problems? List in order of importance: * ____________________

What behaviors or lifestyle habits do you currently engage in regularly that you believe support health? ____________________

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive? ____________________

Current Living Situation

Total number of children: ____________________

Names and ages of children: ____________________

Have you served in the military? ☐ Yes ☐ No

If yes, specify what branch and when? ____________________

Childhood/Family History

Where were you born? ____________________

Please share any traumatic event(s) or abusive situation(s) that occurred during your child: ____________________

List any significant accidents, illnesses, or injuries that occurred during your childhood: ____________________

____

____

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

- [ ] Measles: D I N
- [ ] Mumps: D I N
- [ ] German Measles: D I N
- [ ] Chicken Pox: D I N
- [ ] Whooping Cough: D I N
- [ ] Rubella: D I N
- [ ] Tetanus: D I N
- [ ] Hemophilia: D I N
- [ ] Hep B: D I N

Did you have any vaccination reactions? [ ] Yes [ ] No

Were you adopted? [ ] Yes [ ] No

If yes, at what age? ______________________

Father

If living: age and health: ______________________

If deceased: age, year, and cause of death: ______________________

Mother

If living: age and health: ______________________

If deceased: age, year, and cause of death: ______________________

Parents' marital status:

- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Others ______________________

Names of brother(s)/sister(s), ages and any known healthcare conditions:

____

____

____

____

What is your family heritage? ______________________

Any History of Breast Cancer, Uterine Cancer, Colon Cancer, Prostate Cancer in your family? [ ] Yes [ ] No

If yes, please describe:

____

____

____

____

Personal HIstory

Which of your physicians would you consider in ______________________

charge of your care? Please list name and phone number. ______________________________

When and where did you last receive healthcare? ______________________________

Do you have any known contagious diseases at this time? ☐ Yes ☐ No

If yes, what? ______________________________

List any accidents, illnesses injuries, hospitalizations/surgeries or imaging (X-ray, CAT scan, MRI etc): ______________________________

General

Height: ______________________________

Weight: ______________________________

Weight one year ago: ______________________________

Maximum Weight: ______________________________

When: ______________________________

When during the day is your energy the best? ______________________________

Worst? ______________________________

Main interests and hobbies: ______________________________

Do you use any illegal drugs and/or medicinal marijuana? ☐ Yes ☐ No

If yes, what and how often? ______________________________

Have you ever been in treatment for alcohol or drug use? ☐ Yes ☐ No

If yes, please explain: ______________________________

Do you use tobacco? ☐ Yes ☐ No

If yes, how much? ______________________________

Do you drink alcohol? ☐ Yes ☐ No

If yes, please specify: ☐ Rarely ☐ Occasionally ☐ Daily ☐ Past

How many drinks do you usually have? ______________________________

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs/medications? ______________________________

____

____

____

Any foods: ______________________________

____

____

____

Any environmental chemicals? ______________________________

Current Medications and Supplements

List all medications (from drugstore or prescription) you are taking and dosages if known: ______________________________

____

____

____

List all supplements are taking and dosages if known: ______________________________

____

____

____

Do you use caffeine products (soda, coffee, tea, etc)? ☐ Yes ☐ No

If yes, how much? ______________________________

Nutrition

Do you cook for yourself/your family? ☐ Yes ☐ No

How many meals per day do you usually eat? ______________________________

Do you drink soda pop? ☐ Yes ☐ No

if yes, ☐ once daily ☐ twice daily ☐ greater than three times daily ☐ once weekly ☐ once monthly ☐ Others ____________________________

Adult Mental Health

Have you received previous counseling? ☐ Yes ☐ No

Please specify: ☐ Psychiatrist ☐ Psychologist ☐ School Counselor ☐ Clergy

If yes, when and why? ____________________________

Was it helpful? ____________________________

Have you ever had thoughts of, planned, or attempted suicide? ☐ Yes ☐ No

If yes, please explain: ____________________________

Spiritual Orientation

Please list your spiritual orientation or religion: ____________________________

How active are these beliefs in your life? ☐ Very active ☐ Somewhat active ☐ Not very active

Environmental Exposures

Have you ever lived near a refinery, polluted area or in a home with leaded paint? ☐ Yes ☐ No

If yes, what sort of pollution where you exposed to? ________________

Have you ever lived in a house that had new carpeting, paint, cabinets, or any other refurbishing that seemed to affect your health? ________________

Do you seem particularly sensitive to ro perfumes, gasoline or other vapors? ________________

Do you spray pesticides, herbicides or other chemicals around your home? ☐ Yes ☐ No

H20 Purification System: ☐ Yes ☐ No

Air Purifiers: ☐ Yes ☐ No

Has your home ever been assessed for Radon Exposure? ☐ Yes ☐ No

Other

Please list any other concerns or comments: ________________

Health History

For the following section, please read the question and select from the following responses: Yes, No, or In Past. If No, move on to the next question. If Yes or In past, please specify the severity in the "Others" box, choosing from the following: Mild, Moderate, or Severe.

Endocrine

On average how many hours do you sleep? ________________

Awake rested? ☐ Yes ☐ No ☐ In Past ☐ Others ________________

Insomnia? ☐ Yes ☐ No ☐ In Past ☐ Others ________________

Afternoon Fatigue? ☐ Yes ☐ No ☐ In Past ☐ Others ________________

Dizziness when standing up quickly? ☐ Yes ☐ No ☐ In Past ☐ Others ________________

Hyperthyroid/Hypothyroid? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Hypoglycemia (low blood sugar)? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Difficulty losing weight? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Gain weight easily? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Feel cold - hands, feet, all over? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Thinning of hair on scalp, face, or genitals or excessive falling hair? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Under high amounts of stress? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Neurologic

Seizures? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Muscle weakness? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Loss of memory ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Vertigo or dizziness? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Numbness or Tingling? ☐ Yes ☐ No

☐ In Past
☐ Others ____________________

Easily Stressed?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Loss of balance?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Neck

Pain or stiffness in neck?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Difficulty swallowing?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Lumps in neck?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Immune

Reactions to immunizations?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Chronically swollen glands?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Slow would healing?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Diagnosed with Chronic Fatigue Syndrome?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Chronic infections?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Night sweats?
☐ Yes ☐ No

☐ In Past
☐ Others ____________________

Ears

Ringing in ears?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Ear aches?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Impaired hearing?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Eyes

Impaired vision?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Cataracts?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Glaucoma?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Tearing or dryness?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Spots in vision?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Color blindness?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Eye pain or strain?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Head?

Headaches?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Migraines?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Head injury?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Jaw or TMJ problems?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Nose and Sinus

Stuffiness?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Sinus problems?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Nose bleeds?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Nasal polyps?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Hay fever?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Loss of smell?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Mouth and Throat

Teeth grinding?
☐ Yes ☐ No
☐ In Past
☐ Others ____________

Gum problems? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Jaw clicks? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Frequent sore throat? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Copious saliva? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Sore tongue or lips? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Hoarseness? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Skin

Eczema or hives? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Dryness of skin or scalp? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Dry or flaky skin and/or scalp? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Itching? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Rashes? ☐ Yes ☐ No
☐ In Past
☐ Others ___________________________

Acne/boils? ☐ Yes ☐ No

☐ In Past
☐ Others ______________________

Change in skin color? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Lumps or bumps on skin? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Perpetual hair loss? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Weak nails? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Respiratory/Cardiac

Shortness of breath? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Pain with breathing? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Cough? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Coughing up blood? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Asthma? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Wheezing? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Bronchitis? ☐ Yes ☐ No
☐ In Past

☐ Others ____________________

Emphysema? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Shortness of breath when lying down? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Hearth palpitations? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Inward trembling? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Musculoskeletal

Muscle spasms or cramps? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Joint pain or stiffness? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Arthritis? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Diagnosed with Sciatica (nerve impingement in lower back)? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Weakness? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Broken bones? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Blood

Varicose veins? ☐ Yes ☐ No
☐ In Past

☐ Others ______________________

Anemia? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Easy bleeding or bruising? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Cold hands/feet? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Gastrointestinal

Crave sweets during the day? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Irritable if meals are missed? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Depend on coffee to keep yourself going or started? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Get lightheaded if meals are missed? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Eating relieves fatigue? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Change in thirst? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Change in appetitite? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Greasy or high fat foods cause distress? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Heartburn? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Abdominal pain or cramps? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Excessive belching, burping, or bloating? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Gas immediately following meals? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Use antacids (TUMs, Rolaids)? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Offensive breath? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Nausea/vomiting? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Ulcer? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Gallbladder disease? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

History of gallbladder attacks or stones? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Have you ever had your gallbladder removed? ☐ Yes ☐ No

Liver disease? ☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Hemorrhoids?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Pancreatitis?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Difficulty digesting fruits and vegetables; undigested foods found in stools?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Feeling that bowels do not empty completely?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Diarrhea?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Constipation?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Alternating diarrhea and constipation?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Black stools?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Blood in stools?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Use laxatives frequently?
- [ ] Yes
- [ ] No
- [ ] In Past
- [ ] Others ______________________

Bowel movements: How often? * ______________________________________

Is this a change?
- [ ] Yes
- [ ] No

Mental/Emotional

Treated for memory problems?
- [ ] Yes
- [ ] No

☐ In Past
☐ Others ______________________

Tension? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Depression or Depressed Mood? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Anxiety or nervousness? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Poor concentration? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Mood swings? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Urinary

Increased frequency of urination? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Inability to hold urine? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Pain in urination? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Increased Frequency of urination at night? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Frequent UTI's? ☐ Yes ☐ No
☐ In Past
☐ Others ______________________

Kidney stones? ☐ Yes ☐ No
☐ In Past

☐ Others ____________________

Female Reproductive

Age of first menses? ____________________

Age of last menses? (if menopausal) ____________________

Length of cycle (in days) ____________________

Duration of menses (in days) ____________________

Are your cycles regular?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Bleeding between cycles?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Clotting?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Describe your menstrual flow (heavy, scanty, medium). ____________________

Pain and cramping during periods?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Acne breakouts?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Facial hair growth?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Hair loss/ thinning?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Endometriosis?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Ovarian cysts?
☐ Yes ☐ No
☐ In Past
☐ Others ____________________

Vaginal odor or vaginal discharge? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Date of last PAP? ____________

Abnormal PAP? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Are you sexually active? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Have you been diagnosed with any Sexually Transmitted Infections? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Sexual orientation? ____________

Birth control? (if yes or in past, please specify in "other") ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Difficulty conceiving? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Number of pregnancies? ____________

Number of live births? ____________

Number of miscarriages? ____________

Number of abortions? ____________

Do you do self breast exams? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Breast pain/tenderness? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Breast lumps? ☐ Yes ☐ No ☐ In Past ☐ Others ____________

Menopausal symptoms? ☐ Yes ☐ No

☐ In Past
☐ Others ______________________

Male Reproductive

Are you sexually active?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Sexual orientation?	____	
Increased sex drive?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Decrease in libido?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Decrease in fullness of erections?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Premature ejaculation?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Diagnosed with any Sexually Transmitted Infections?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Discharge or sores?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Testicular masses?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Testicular pain?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Prostate disease?	☐ Yes	☐ No
	☐ In Past	
	☐ Others ______________________	
Hernias?	☐ Yes	☐ No

☐ In Past
☐ Others ___________________________

Other

Rate your stress level on a scale of 1-10 during the average week: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Thank you for taking the time to complete this questionnaire.