Synergy Integrated Health Extremity Forms

The following forms are for extremity problems. (Hip, Knee, ankle, foot, shoulder, elbow, wrist, or hand).

Please take the time to fill out completely as it will help understand the best approach for helping you.

In order to get you better faster, we look at your health issue from the following approach:

Structural: *(*Arthritis, Degeneration, Injury, balance problems*)*

Metabolic: (Nutritional. Inflammatory, or Autoimmune problems)

Neurological: (Movement or Sensory problems)

This unique approach allows us to identify areas of dysfunction in order to maximize your healing.

Please bring or wear shorts for your examination

After your examination you will be scheduled for a follow up visit where the doctor will review if we can help you, your care plan, and any financial responsibility you may have. **It is our office policy your spouse attends the doctors report.** At that time you will receive treatment so please allow 30 minutes for this visit.

Metabolic Assessment Form

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** ______________

PART I

Please list your 5 major health concerns in order of importance:

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI (continued)				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Symptom				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Symptom				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Symptom				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Symptom				
Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Symptom				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Symptom				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII

Symptom				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*

Symptom				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Symptom				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Symptom				
Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*

Symptom				
How many years have you been menopausal?	_______ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? ________

How many caffeinated beverages do you consume per day? ________

How many times do you eat out per week? ________

How many times do you eat raw nuts or seeds per week? ________

Rate your stress level on a scale of 1-10 during the average week: ________

How many times do you eat fish per week? ________

How many times do you work out per week? ________

List the three worst foods you eat during the average week: ____________ ____________ ____________

List the three healthiest foods you eat during the average week: ____________ ____________ ____________

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

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Synergy Integrated Health and Medicine

Dr. John Parker
Dr. Alexa Parker
4343 West Henderson Blvd.
Tampa, FL 33629
813-254-5200

Name: ____ **Date:** ___________________________

Please take several minutes to answer these questions so Dr. Parker can help you get better faster. (Please circle as many that apply)

1. How have you taken care of your health in the past?

   a. Medications
   b. Emergency Room
   c. Routine Medical
   d. Exercise
   e. Nutrition/Diet
   f. Holistic Care
   g. Vitamins
   h. Chiropractic
   i. Other (please specify)

   How did these previous methods work for you?

   a.
   b.
   c.
   d.
   e.
   f.
   g.
   h.
   i.

2. How have others been affected by your health condition?

   a. No one is affected
   b. Haven't noticed any problem
   c. They tell me to do something
   d. People avoid me

3. What are you afraid this might be (or beginning) to affect (or will affect)?

   a. Job
   b. Kids
   c. Future ability
   d. Marriage
   e. Self-esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom

4. Are there health conditions you are afraid this might turn into?

    a. Family health problems
    b. Heart disease
    c. Cancer
    d. Diabetes
    e. Arthritis
    f. Fibromyalgia
    g. Depression
    h. Chronic fatigue
    i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

____

____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)

____

____

What are you most concerned with regarding your problem**?** ____

____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

____

____

What would be different/better without this problem? Please be specific.

____

____

What do you desire most to get from working with us? ____

____

On the scale of 1 to 10 (with 10 being the best) what is your level of commitment to regaining your health? ___

____

Confidential Patient Intake Information

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient Information

Patient Name ____

Today's Date ______________ Date of Birth _______________

Social Security # ____

Address ____

City ____

State __________________________ Zip __________________

Gender: ❒ Male ❒ Female Height _______ Weight _______

❒ Single ❒ Married ❒ Partnered ❒ Engaged
❒ Separated ❒ Divorced ❒ Widowed ❒ Minor

How many children do you have? __________________________

Please list any family members being treated here ____________

____

Occupation ____

Employer/School ____

Employer/School Address _________________________________

____

Employer/School phone #: (_____) ________________________

Contact Information

Home Phone (______) __________________________________

Cell Phone (______) ___________________________________

Email address ____

May we contact you via (please check for all applicable):

❒ Home phone ❒ Cell ❒ Work phone ❒ Email

In case of emergency please contact:

Name ____

Relationship ____

Home Phone (______) __________________________________

Alternate Phone (______) ________________________________

Spouse's/Partner's name _________________________________

Spouse's/Partner's employer ______________________________

Who referred you? ______________________________________

Patient Condition

What is your major complaint *(be as specific as possible)* ____

____

When did you condition/symptoms/pain first appear? *(specific date, days ago, weeks, ago, etc.)* ______________________________

Is this condition getting progressively worse? ❒ Yes ❒ No ❒ Constant ❒ Comes and goes

When is it worse? ❒ Morning ❒ Afternoon ❒ Evening ❒ Changes time of day

Does it interfere with: ❒ Work ❒ Sleep ❒ Daily routines ❒ Recreation ❒ Other ____________________________

How long has it been since you really felt good? ____

Other doctors seen for this condition: ❒ MD ❒ DC ❒ DO ❒ DDS ❒ Other ______________________________

Does the condition/symptom/pain radiate? ❒ Yes ❒ No

If yes, where and how frequently ____

How long/often does the radiation occur/last? ______________________________

Do you have: ❒ Numbness ❒ Tingling ❒ Weakness

Describe ____

List and mark the severity of your condition/symptoms/pain on the scale below:

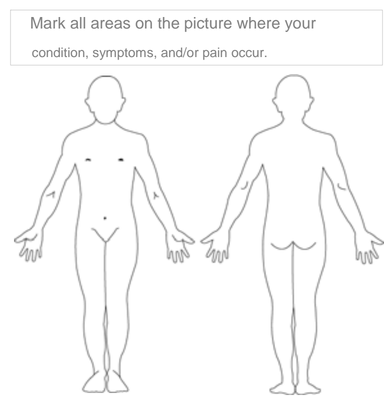
Body part ________________ ____

0 (None) 5 *(Severe) 10*

Body part ________________ ____

0 (None) 5 *(Severe) 10*

Mark all areas on the picture where your condition, symptoms, and/or pain occur.



Type of Pain:

❒ Sharp ❒ Dull ❒ Throbbing ❒ Tingling ❒ Other ________________
❒ Shooting ❒ Burning ❒ Aching ❒ Numbness

What activities or positions aggravate your condition?

❒ Bending ❒ Coughing ❒ Getting up/down ❒ Driving ❒ Lifting ❒ Lying down
❒ Sneezing ❒ Standing ❒ Staining at stool ❒ Turning head ❒ Twisting ❒ Walking

Patient Condition

What activities or positions relieve your condition:

❐ Heat ❐ Lying down ❐ Sitting ❐ Sitting ❐ Stretching ❐ Other
❐ Ice ❐ Medication ❐ Massage ❐ Standing ❐ Exercise

Have you ever had this condition before? ❐ Yes ❐ No If yes, when? ______________________________

Were you treated for this condition or a similar one before? ❐ Yes ❐ No If yes, when/by whom? ______________________________

____

Health History

Do you have any allergies? (food, contact, environmental) ______________________________

List any prescribed medications, over the counter medications, vitamins, herbs and supplements ______________________________

____

When was your last: Physical examination _______________ Blood/lab work _______________ X-ray study _______________

Injuries/Surgeries you've had and when? ______________________________

____

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below***

❐ Ankylosing spondulitis
❐ Anxiety
❐ Arthritis
❐ Asthma
❐ Bleeding disorder
❐ Blurred vision
❐ Bowel/Bladder problems
❐ Buzzing in ear
❐ Cancer
❐ Carpal tunnel
❐ Celiac disease (gluten)
❐ Chest pains
❐ Chronic fatigue
❐ Cold hands or feet
❐ Colitis/discerticulitis
❐ Compression fractures
❐ Connective tissue issues
❐ COPD (bronchitis/emphy)
❐ Depression
❐ Diabetes
❐ Digestive/bowel problems
❐ Dizziness or vertigo
❐ Fibromyalgia
❐ Fusions (spinal, joint)
❐ Gout
❐ Hear disease
❐ Hepatitis (A, B, C, etc.)
❐ Herpes
❐ High blood pressure
❐ Hip replacement
❐ HIV/AIDS
❐ Kidney disease
❐ Knee surgery
❐ Liver disease
❐ Marfan syndrome
❐ Multiple sclerosis
❐ Osteoporosis/penia
❐ Parkinson's disease
❐ Rotator cuff problem
❐ STI/STD
❐ Shoulder surgery
❐ Spinal surgery
❐ Stroke/TIA
❐ Thyroid problems
❐ Tuberculosis
❐ Other ______________________________
❐ Other ______________________________

Are there any conditions that run in your family? ❐ Yes ❐ No If yes, what condition(s) and which family member? _______________

____

Personal and Social Health History

Are you currently pregnant, or do you think you may be pregnant? ❐ Yes ❐ No If yes, how many weeks? _______________

How many hours per week do you typically work/attend school? ❐ <20 hrs ❐ 20 hrs ❐ 30 hrs ❐ 40 hrs ❐ 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc.)? ______________________________

Do you exercise? ❐ Yes ❐ No If yes, how often and what type? ______________________________

Do you or does anyone else ever "crack" you neck/back/joints? ❐ Yes ❐ No If yes, how often and what body parts? _______________

How would you rate your eating habits? ❐ Excellent ❐ Pretty good ❐ Could be better ❐ Needs improvement

How well do you sleep? ❐ Excellent ❐ Pretty good ❐ Restless ❐ Can't sleep ❐ Wake up often

How many hours of sleep do you get daily? _______ hours *and* Do you feel rested in the morning? ❐ Yes ❐ No

How is your energy overall? ❐ Full power ❐ OK ❐ Low ❐ Sporadic/Generally fatigued ❐ I depend on caffeine for energy

How do you feel your immune system is working? ❐ Strong ❐ OK ❐ Low

What do you hope to receive from our program? ______________________________

Thank you for completing our health care questionnaire