Welcome *to Synaptic Chiropractic, PA*

Name: _____ Nickname: _____ Current age:_____ Date of Birth:_____

Child's Home Address _____ City _____ State _____ Zip _____

Parent #1 _____ Phone (h) _____ (work) _____ (cell) _____

Parent #2 _____ Phone (h) _____ (work) _____ (cell) _____

Parent's Email _____

Child's Sex: Male O Female O Purpose of the appointment with doctor today: _____

Has child ever received chiropractic care? (Please circle) Yes O No O Referred by _____

If Child was adopted: ***Adoption Information***

Child's age when adopted _____ Date of Adoption _____

Known health history of child _____
(Use back of page for additional information as needed)

Pregnancy Information

Pregnancy History: _____
Pre-natal Supplements? Yes O No O Omega 3 Supplement? Yes O No O Pro-biotic Supplement? Yes O No O
Organic Diet? Yes O No O Any Prolonged Emotional Stress During Pregnancy? Yes O No O
Any Loss Suffered During Pregnancy? (Example: death, loss of job or pet) Yes O No O Comment: _____

Medications taken during pregnancy? _____
Any problems during pregnancy and/or labor? (Use back of page for additional information as needed)
_____

Delivery/Birth History: _____

Birth Information

Birth Weight: _____ Birth Length: _____ Epidural: Yes O No O
Type of Birth: Vaginal O Forceps O Breech O Cesarean O Home O Birthing Center O Hospital O
Apgar Scores: _____ Jaundice (yellow) at Birth? Yes O No O Cyanosis (blue) Yes O No O

Congenital Anomalies/Defects: _____

Infant Feeding: Breast O For how long? _____ Bottle O Which Formula? _____

Any issues with feeding? _____

Number of hours child sleeps daily: _____ Quality of Sleep: Good O Fair O Poor O

Has child had any vaccinations? _____

Number of Siblings: _____ Siblings Name, Age and Sex: _____

Date of last visit to any doctor: _____ Reason for that visit: _____

Has child ever been treated on an emergency basis? _____

At what age did child respond to sound: _____ Crawl: _____ Follow object with eyes: _____

Current Health Habits

Yes	No		Comments	*Notes by Doctor*
O	O	Diet (Eating healthy foods)?	_____	_____
O	O	Has child been in any accidents?	_____	_____
O	O	Exercise Regularly?	_____	_____
O	O	Hobbies/Sports injuries?	_____	_____

Sleeping Posture: O Side O Stomach O Back (Comment) _____

How are things going at school? (Comment) _____

Performance: O Good O Poor (Comment) _____

Interaction: O Good O Poor (Comment) _____

Does child have emotional stress? Family O School O Other _____

Any Present Complaints: _____

Pain or Problem started on _____Feels like: _____ Sharp Dull Ache Burns Numbness

Is condition interfering with school? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____ Using any home remedies? _____

⇨ Please note **ANY** of the following signals that have presented, even if you feel they are unrelated:

<Under-Aroused>	*<Un-Stable>*	*<Over –Aroused>*
O Poor Attention	O Migraines	O Cold hands
O Impulsive	O Headaches	O Cold feet
O Easily Distracted	O Seizures	O Tight Muscles
O Disorganized	O Sleepwalking	O Teeth grinding
O Depressed	O Hot flashes	O Anxiety
O Lacking motivation		O Heart Palpitations
O Poor Concentration	O Food sensitivities	O Restless Sleep
O Spaciness	O Bed wetting	O Poor expression of emotions
O Constipation	O Eating Disorder	O poor immune system
O Low Pain Threshold	O Bipolar Disorder	O Racing Mind
O Difficulty waking up	O Mood Swings	O High Blood Pressure
O Worry	O Panic Attacks	O Accelerated Aging
O Irritable		O Irritable Bowel
O Low Energy		

<Exhausted>

O Cancer	O Rheumatoid Arthritis	O Diabetes
O Depression	O Chronic Fatigue Syndrome	O Epstein-Barr Syndrome

O Eczema or Skin problems	O Pins & Needles in Legs or Arms	O Buzzing in Ears	O Vision Problems
O Low Blood Pressure	O Loss of Smell or Taste	O Dyslexia	O Loss of Memory
O Numbness in Fingers & Toes	O Diarrhea	O Dizziness or Fainting	O Sinus Problems
O Shortness of Breath	O Loss of Balance	O Face Flushed	O Bladder Problems
O Ear Infections	O Urinary Infections	O Speech Difficulty	O ADHD or ADD

Has child been under drug and medical care? _____

What medications does the child take? _____

How long has child been taking them? _____ Side effects noticed: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine my child for further evaluation:

_____ _____ _____

Signature (Parent or Guardian) Printed name of person completing this form *Date*

SYSTEMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Vegetarian: Yes No

INSTRUCTIONS: Number only the boxes which apply to you. Leave blank if you don't have the problem.
* Write 1 in the box for MILD symptoms (occurs rarely).
* Write 2 in the box for MODERATE symptoms (occurs several times a month).
* Write 3 in the box for SEVERE symptoms (occurs almost constantly).

Please do not use checkmarks in the boxes - fill in the boxes with a number or leave blank!

GROUP 1

1 ☐ Acid foods upset
2 ☐ Get chilled often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meal
6 ☐ Keyed up - fail to calm
7 ☐ Cut heals slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach often

GROUP 2

21 ☐ Joint stiffness on arising
22 ☐ Muscle-leg-toe cramps at night
23 ☐ "Butterfly" stomach, cramps
24 ☐ Eyes or nose watery
25 ☐ Eyes blink often
26 ☐ Eyelids swollen, puffy
27 ☐ Indigestion soon after meals
28 ☐ Always seems hungry; feels "lightheaded" often
29 ☐ Digestion rapid
30 ☐ Vomiting frequent
31 ☐ Hoarseness frequent
32 ☐ Breathing irregular
33 ☐ Pulse slow; feels "irregular"
34 ☐ Gagging reflex slow
35 ☐ Difficulty swallowing
36 ☐ Constipation, diarrhea alternating
37 ☐ "Slow starter"
38 ☐ Get "chilled" infrequently
39 ☐ Perspire easily
40 ☐ Circulation poor, sensitive to cold
41 ☐ Subject to colds, asthma, bronchitis

GROUP 3

42 ☐ Eat when nervous
43 ☐ Excessive appetite
44 ☐ Hungry between meals
45 ☐ Irritable before meals
46 ☐ Get "shaky" if hungry
47 ☐ Fatigue, eating relieves
48 ☐ "Lightheaded" if meals delayed
49 ☐ Heart palpitates if meals missed or delayed
50 ☐ Afternoon headaches
51 ☐ Overeating sweets upsets
52 ☐ Awaken after few hours sleep - hard to get back to sleep
53 ☐ Crave candy or coffee in afternoons
54 ☐ Moods of depression - "blues" or melancholy
55 ☐ Abnormal craving for sweets or snacks

GROUP 4

56 ☐ Hands and feet go to sleep easily, numbness
57 ☐ Sigh frequently, "air hunger"
58 ☐ Aware of "breathing heavily"
59 ☐ High altitude discomfort
60 ☐ Opens windows in closed rooms
61 ☐ Susceptible to colds and fevers
62 ☐ Afternoon "yawner"
63 ☐ Get "drowsy" often
64 ☐ Swollen ankles, worse at night
65 ☐ Muscle cramps, worse during exercise; get "charley horses"
66 ☐ Shortness of breath on exertion
67 ☐ Dull pain in chest or radiating into left arm, worse on exertion
68 ☐ Bruise easily, "black and blue" spots
69 ☐ Tendency to anemia
70 ☐ "Nose bleeds" frequent
71 ☐ Noises in head, or "ringing in ears"
72 ☐ Tension under the breastbone, or feeling of "tightness", worse on exertion

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

- 73 ☐ Dizziness
- 74 ☐ Dry skin
- 75 ☐ Burning feet
- 76 ☐ Blurred vision
- 77 ☐ Itching skin and feet
- 78 ☐ Excessive falling hair
- 79 ☐ Frequent skin rashes
- 80 ☐ Bitter, metallic taste in mouth in mornings
- 81 ☐ Bowel movements painful or difficult
- 82 ☐ Worrier, feels insecure
- 83 ☐ Feeling queasy; headache over eyes
- 84 ☐ Greasy foods upset
- 85 ☐ Stools light colored
- 86 ☐ Skin peels on foot soles
- 87 ☐ Pain between shoulder blades
- 88 ☐ Use laxatives
- 89 ☐ Stools alternate from soft to watery
- 90 ☐ History of gallbladder attacks or gallstones
- 91 ☐ Sneezing attacks
- 92 ☐ Dreaming, nightmare type bad dreams
- 93 ☐ Bad breath (halitosis)
- 94 ☐ Milk products cause distress
- 95 ☐ Sensitive to hot weather
- 96 ☐ Burning or itching anus
- 97 ☐ Crave sweets

GROUP 6

- 98 ☐ Loss of taste for meat
- 99 ☐ Lower bowel gas several hours after eating
- 100 ☐ Burning stomach sensations, eating relieves
- 101 ☐ Coated tongue
- 102 ☐ Pass large amounts of foul-smelling gas
- 103 ☐ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 ☐ Mucous colitis or "irritable bowel"
- 105 ☐ Gas shortly after eating
- 106 ☐ Stomach "bloating" after eating

GROUP 7

(A)

- 107 ☐ Insomnia
- 108 ☐ Nervousness
- 109 ☐ Can't gain weight
- 110 ☐ Intolerance to heat
- 111 ☐ Highly emotional
- 112 ☐ Flush easily
- 113 ☐ Night sweats
- 114 ☐ Thin, moist skin
- 115 ☐ Inward trembling
- 116 ☐ Heart palpitates
- 117 ☐ Increased appetite without weight gain
- 118 ☐ Pulse fast at rest
- 119 ☐ Eyelids and face twitch
- 120 ☐ Irritable and restless
- 121 ☐ Can't work under pressure

(B)

- 122 ☐ Increase in weight
- 123 ☐ Decrease in appetite
- 124 ☐ Fatigue easily
- 125 ☐ Ringing in ears
- 126 ☐ Sleepy during day
- 127 ☐ Sensitive to cold
- 128 ☐ Dry or scaly skin
- 129 ☐ Constipation
- 130 ☐ Mental sluggishness
- 131 ☐ Hair coarse, falls out
- 132 ☐ Headaches upon arising, wear off during day
- 133 ☐ Slow pulse, below 65
- 134 ☐ Frequency of urination
- 135 ☐ Impaired hearing
- 136 ☐ Reduced initiative

(C)

- 137 ☐ Failing memory
- 138 ☐ Low blood pressure
- 139 ☐ Increased sex drive
- 140 ☐ Headaches, "splitting or rending" type
- 141 ☐ Decreased sugar tolerance

(D)

- 142 ☐ Abnormal thirst
- 143 ☐ Bloating of abdomen
- 144 ☐ Weight gain around hips or waist
- 145 ☐ Sex drive reduced or lacking
- 146 ☐ Tendency to ulcers, colitis
- 147 ☐ Increased sugar tolerance
- 148 ☐ Women: menstrual disorders
- 149 ☐ Young girls: lack of menstrual function

(E)

- 150 ☐ Dizziness
- 151 ☐ Headaches
- 152 ☐ Hot flashes
- 153 ☐ Increased blood pressure
- 154 ☐ Hair growth on face or body (female)
- 155 ☐ Sugar in urine (not diabetes)
- 156 ☐ Masculine tendencies (female)

(F)

- 157 ☐ Weakness, dizziness
- 158 ☐ Chronic fatigue
- 159 ☐ Low blood pressure
- 160 ☐ Nails weak, ridged
- 161 ☐ Tendency to hives
- 162 ☐ Arthritic tendencies
- 163 ☐ Perspiration increase
- 164 ☐ Bowel disorders
- 165 ☐ Poor circulation
- 166 ☐ Swollen ankles
- 167 ☐ Crave salt
- 168 ☐ Brown spots or bronzing of skin
- 169 ☐ Allergies - tendency to asthma
- 170 ☐ Weakness after colds, influenza
- 171 ☐ Exhaustion - muscular and nervous
- 172 ☐ Respiratory disorders

SYSTEMS SURVEY FORM - PAGE 3

GROUP 8

173 ☐ Apprehension
174 ☐ Irritability
175 ☐ Morbid fears
176 ☐ Never seems to get well
177 ☐ Forgetfulness
178 ☐ Indigestion
179 ☐ Poor appetite
180 ☐ Craving for sweets
181 ☐ Muscular soreness
182 ☐ Depression; feelings of dread
183 ☐ Noise sensitivity
184 ☐ Acoustic hallucinations
185 ☐ Tendency to cry without reason
186 ☐ Hair is coarse and/or thinning
187 ☐ Weakness
188 ☐ Fatigue
189 ☐ Skin sensitive to touch
190 ☐ Tendency toward hives
191 ☐ Nervousness
192 ☐ Headache
193 ☐ Insomnia
194 ☐ Anxiety
195 ☐ Anorexia
196 ☐ Inability to concentrate; confusion
197 ☐ Frequent stuffy nose; sinus infections
198 ☐ Allergy to some foods
199 ☐ Loose joints

FEMALE ONLY

200 ☐ Very easily fatigued
201 ☐ Premenstrual tension
202 ☐ Painful menses
203 ☐ Depressed feelings before menstruation
204 ☐ Menstruation excessive and prolonged
205 ☐ Painful breasts
206 ☐ Menstruate too frequently
207 ☐ Vaginal discharge
208 ☐ Hysterectomy/ovaries removed (write number 3)
209 ☐ Menopausal hot flashes
210 ☐ Menses scanty or missed
211 ☐ Acne, worse at menses
212 ☐ Depression of long standing

MALE ONLY

213 ☐ Prostate trouble
214 ☐ Urination difficult or dribbling
215 ☐ Night urination frequent
216 ☐ Depression
217 ☐ Pain on inside of legs or heels
218 ☐ Feeling of incomplete bowel evacuation
219 ☐ Lack of energy
220 ☐ Migrating aches and pains
221 ☐ Tire too easily
222 ☐ Avoids activity
223 ☐ Leg nervousness at night
224 ☐ Diminished sex drive

IMPORTANT

Please list the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

~~BARNES THYROID TEST~~

~~This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.~~

N/A

N/A

N/A

~~PRE-MENSES FEMALES AND MENOPAUSAL FEMALES~~

~~Any two days during the month~~

~~FEMALES HAVING MENSTRUAL CYCLES~~

~~The 2nd and 3rd day of flow OR any 5 days in a row~~

~~MALES~~

~~Any 2 days during the month~~

~~You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.~~

~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____

N/A

N/A

SYSTEMS SURVEY FORM - PAGE 4

Please list any medications you are taking: ☐ No Medications

Please list any vitamins, herbs, or supplements you are taking: ☐ No Vitamins

Please list any allergies you have: ☐ No Allergies

Please list any surgeries you have had in the past 12 months: ☐ No Recent Surgeries

Please list any other surgeries or medical procedures you have had: ☐ No Other Surgeries

TO BE COMPLETED BY DOCTOR

Blood Pressure: Recumbent _____ Standing _____

Pulse: Recumbent _____ Standing _____

Hema-Combistix Urine Readings: pH _____ Albumin % _____ Glucose % _____

Occult Blood _____ pH of Saliva _____ pH of Stool Specimen _____

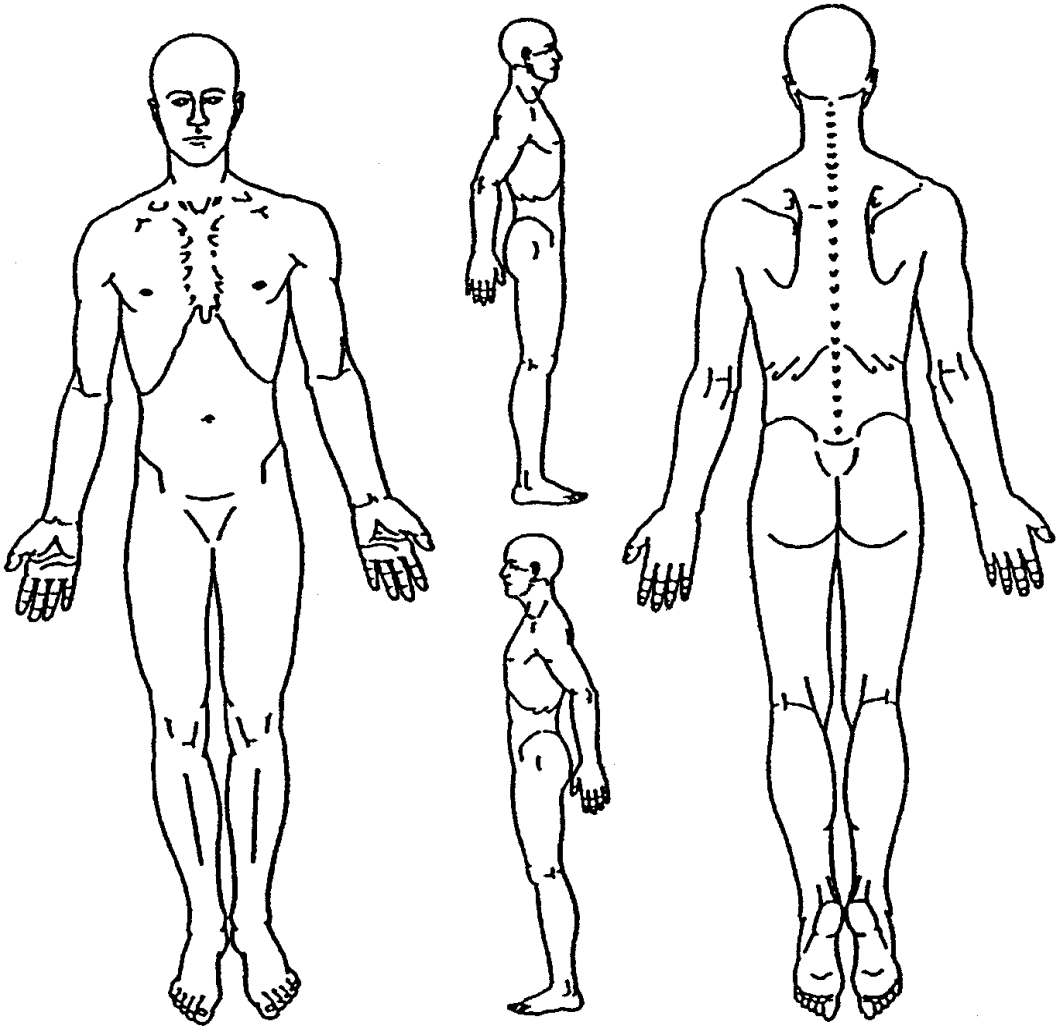
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

SYSTEMS SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____