

Synergy Chiropractic

Patient #: _____

• All information is kept STRICTLY CONFIDENTIAL. Please complete as accurately as possible. •

• ABOUT YOU •

Full Name: _____

Prefer to be called: _____

Date of Birth: ____ / ____ / ____ Age: ____

SSN: _____ - _____ - _____

Marital Status: Single Separated Divorced

Address: _____

Married Widowed

City: _____ State: _____ ZIP: _____

Home Telephone: (____) _____ - _____

Work Phone: (____) _____ - _____

Mobile Phone: (____) _____ - _____

Employer: _____

E-mail: _____ @ _____

Employer Address: _____

How did you hear of our office?: _____

City: _____ State: _____ ZIP: _____

Occupation: _____

Spouse's Name: _____

• EMERGENCY CONTACT •

Name: _____ Relationship: _____

Telephone: (____) _____ - _____ Alternate Telephone: (____) _____ - _____

• GENERAL QUESTIONS (approximate dates if unknown) •

Have you ever been to a chiropractor before? No Yes → If "Yes," when? _____ Name: _____

Were you ever **injured in an automobile accident** as EITHER passenger or driver? No Yes → If "Yes," when? _____

Were you ever **injured at work** or as the result of employment? No Yes → If "Yes," when? _____

Are you willing to participate as a member of your health care team and make a commitment to yourself in improving your condition?
 No Yes

Your **Primary Care Physician's** Name, Address and Telephone:

• IMPORTANT ACCOUNT INFORMATION – PLEASE READ •

Insurance Information: I understand and agree that health and accident insurance policies re an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credit to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Consent of Professional Services and Release of Information: I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case, and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient Signature (Parent or Guardian Signature if Patient is a Minor)

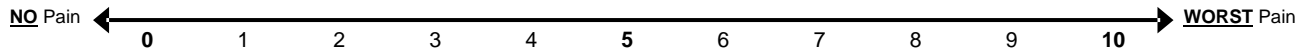
Date Signed

Name: _____

Date: _____

• REASON FOR YOUR VISIT •

In the spaces below, please indicate the symptom(s) you experience(d) that either prompted today's visit or are generally of concern to you (one per line). Indicate those symptoms that are more troublesome **first**. At the end of each line, please rate the severity of each of these symptoms according to the condition indicated at the top of each column. Please use the following scale to rate your symptoms (if you need additional space, please use the reverse side of this page):



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

<i>AT <u>BEST</u></i>	<i>ON <u>AVERAGE</u></i>	<i>AT <u>WORST</u></i>

Is your **MAIN condition** due to a(n): Automobile Accident Work Injury Other Accident Illness Other / Unknown Cause

Date Symptoms Appeared (approximate if date unknown): _____ Did your symptoms appear: Suddenly Gradually

Are your symptoms: Improving Getting Worse About the Same Intermittent ("Come and Go")

How often do you experience your symptom(s)? Constantly (100%) Frequently (75%) Intermittently (50%) Occasionally (25%) Rarely (≤10%)

What seems to **AGGRAVATE** your condition?: _____

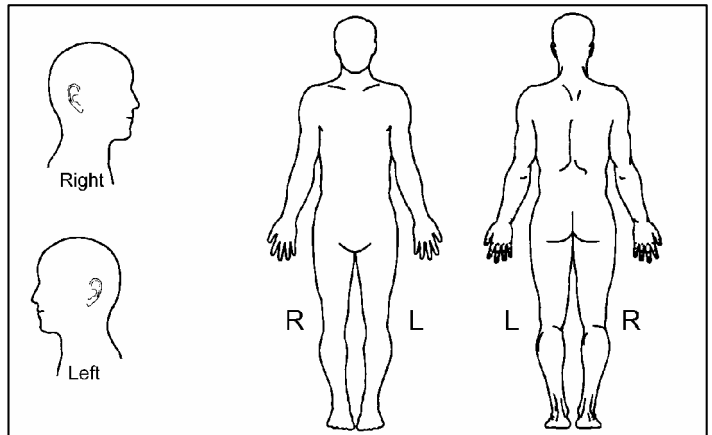
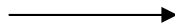
Is there anything that **EASES** your symptoms? No Yes (describe) _____

Do your symptoms **wake you up at night**? No Yes (describe) _____

Are your symptoms **worse during any particular time of day**? No Yes (describe) _____

On the diagram at the right, please outline the areas of your pain and/or discomfort. Use the following symbols, as applicable, to diagram areas of discomfort (you may also write in any other description that applies):

- A = Aching
- B = Burning
- C = Cold
- H = Hypersensitivity
- N = Numbness
- R = Throbbing
- S = Stabbing
- T = Tingling



Have you had **these or similar symptoms before**? No Yes → If "Yes," when? _____

Have you seen **another doctor for this condition**? No Yes, a medical physician Yes, another chiropractor

Other doctor's name: _____ Date Consulted: _____ Were X-Rays Taken? No Yes

Please List Anything Else That is of a Health Concern:

Patient #: _____

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Patient Name (Printed): _____ Patient Signature: _____

Please check mark each of the conditions below that you are currently experiencing:

MUSCULOSKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps in the breast

ARE YOU PREGNANT?

- Yes
- No

GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficulty chewing
- Difficulty swallowing
- Excessive thirst
- Nausea
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

HABITS

- Cigarettes
- Alcohol abuse
- Coffee or tea
- Exercise
- Drug abuse
- _____

CARDIO VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficulty breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung Problems
- Varicose veins

EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficulty breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw pain

Patient Accepted?

- Yes
- No

Doctors Signature:

Synergy Chiropractic

To all Synergy Chiropractic Patients:

Synergy Chiropractic is dedicated to providing you with the highest quality of healthcare services. To keep the registration process as smooth as possible, please be aware of the following guidelines:

- ❖ Please bring your medical insurance card with you if and when there has been any change or update to your health insurance policy. We will make a photocopy for our records and update your file.
- ❖ If your health insurance requires a co-payment to see a physician, it **MUST** be paid at the time of your appointment. If you cannot make the co-payment at the time of your appointment, we may ask that you please make arrangements with us ahead of time.
- ❖ If you are unable to keep a scheduled appointment in the future, please call at least 24 hours in advance to cancel the appointment so that someone else who needs to be seen can be scheduled in your place.

Signing below acknowledges that you understand these guidelines and were given a copy of the NOTICE OF PRIVACY PRACTICES in accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Please ask to speak with the office administrator if you have any questions or concerns. Thank you very much for your cooperation.

Patient Name (Print)

Patient Signature (Parent or Legal Guardian, if patient is a minor)

Date

SYNERGY CHIROPRACTIC, INC.
AUTHORIZATION OF TREATMENT
ASSIGNMENT OF INSURANCE BENEFITS
FINANCIAL AGREEMENT

Authorization must be signed by patient if age 18 or over or by a minor (under 18) emancipated or otherwise eligible pursuant to KRS 214.185 (See Consent Procedure); or by the parent or legal guardian for any other minor or by the patient's guardian if the patient is disabled.

PATIENT: _____ DATE: _____

1. I hereby consent to treatment by Synergy Chiropractic, Inc. believing that I am suffering from a condition requiring chiropractic treatment, and authorize such care and diagnostic procedures. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of any condition.
2. I understand that no assurances or guarantees have been given by anyone concerning this treatment or the results that may be obtained.
3. I acknowledge that it has been explained to me the diagnostic and treatment procedures to be provided are limited to chiropractic treatment.
4. I hereby authorize treatments and/or procedures and the use of same or further medical study. I further authorize Synergy Chiropractic, Inc. to use their discretion in allowing persons to observe such treatment, testing or treatments in the furtherance of diagnostic research.
5. I hereby authorize Synergy Chiropractic, Inc. to release medical and any psychological information to third party payors.
6. I understand that charges will be made for treatment and the use of laboratory and diagnostic testing and any other services performed in accordance with the prescribed treatment plan all of which I agree to pay. I hereby assign all hospital insurance benefits, workers compensation benefits, personal injury protection benefits and any other insurance benefits that may arise to Synergy Chiropractic, Inc. A photocopy of this authorization shall be considered as effective and valid as the original.
7. I understand that should the status of my account become delinquent, any charges resulting from the collection of said account are incurred by me. I further understand that should my account be sent to our collections attorneys after 3 written notices, a 35% fee will be assessed to your account to cover our collections fees.

PATIENT'S SIGNATURE (If minor, parent or guardian)

Witness

**SYNERGY
CHIROPRACTIC**
1412 Gloria Terrell Drive Suite 4
Wilder, KY 41076

I _____, do hereby give my consent
to allow Synergy Chiropractic and its representatives to take x-rays as deemed
appropriate by the examining doctor of chiropractic.

Signature

Date

FEMALES ONLY

I hereby declare that to my knowledge, I am not pregnant.

Signature

Date