Dr. Tim Harrigan
*Chiropractic Physician*
6015 E. Grant Road
Tucson, AZ 85712
520-818-8857

# New Practice Member Intake Form

First Name: ______________________
Last Name: ______________________
Nickname: ______________________
Address: ______________________
City: ______________________
State: ________ Zip Code: __________
Age: ________ Date of Birth: __________
Sex: ( ) Male ( ) Female
( ) Single ( ) Married ( ) Divorced ( ) Separated
( ) Widowed
Social Security #: ______- ______- ______
Home Phone: ______________________
Work Phone: ______________________
Cell Phone: ______________________
Email Address: ______________________
***Do you prefer a TEXT MESSAGE or EMAIL for appointment reminders?*** (Please circle preference)

Type of work: ______________________
Insurance: ( ) Work Comp ( ) Auto ( ) MA
( ) Medicare ( ) Private: __________
Whom may we thank for referring you to our office? ______________________
How were you referred to our office?
( ) Yellow pages ( ) Lecture ( ) Drive by
( ) Coupon ( ) Screening Where? __________
______________________
( ) Mailing - which one? __________
( ) Other: ______________________

In case of an emergency, please contact:
Name: ______________________
Phone: ______________________
Relationship: ______________________

# Your Health Profile

At Synergy Wellness, we realize that we can only help a person as much as they want to help themselves. We cannot force upon someone the desire to get healthy and stay there, but, we can provide the necessary tools when that person arrives at that point. While filling this out, please be honest with yourself, but more importantly, start to envision your ideal health so we know how far we can take you!

Please rate your perceived overall health status:

**Poor 1 2 3 4 5 6 7 8 9 10 Excellent**

What are your health objectives? ______________________
______________________

Name/Address/Phone of the last doctor who put you on a health development program? __________
______________________

Were you able to stay on the program? Y N How long? ______________________

What were your results? ______________________

Are you healthier today than you were 5 years ago? Y N Not Sure

If so, what did you do to improve your health? ______________________
______________________

If not, why do you think your health declined? ______________________
______________________



Doctor Initials:__________

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Patient Name ______________________________________________________ Date ________________

Will you be healthier 5 years from now than you are today? Y N Not Sure

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline? ____________________________________________
____________________________________________________________________________________

After making these changes in your life, how do you expect your health to be 5 years from now?
____________________________________________________________________________________

**Have you had previous chiropractic care?** Y N

If yes, what was the doctor's name? ________________________________________________________

What was the approximate date of your last visit? ____________________________________________

What was the duration of your care? _______________________________________________________

**Were you aware that:**

--Doctors of Chiropractic work with the nervous system? ___Yes ___No
--The nervous system controls all bodily functions and systems? ___Yes ___No
--Chiropractic is the largest natural healing profession in this world? ___Yes ___No
--If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? ___Yes ___No

What other wellness professionals are currently parts of your health care team?
( ) Massage Therapist ( ) Acupuncturist ( ) Naturopath ( ) Homeopath
( ) Other: ______________________________________________________

How many Medical Doctor's office visits did you and your family have last year?
( ) None ( ) Less that 5 ( ) More than 5 ( ) More than 10

Is your current condition the result of a **recent**: ( ) auto accident? ( ) work related injury

What was the date of injury? __________________________

If so, please inform the front desk staff immediately to obtain additional necessary paperwork.



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Patient Name ______________________________ Date ______________

**Please describe below, in the following 2 sections, your primary, secondary and additional reasons, if any, for seeking care in our office:**

**Primary Complaint** (*List one only*): ______________________________

When did you first experience this problem? ______________________________

How did this problem first begin? ______________________________

What seems to aggravate this problem? ______________________________

What have you **tried to relieve this problem** (i.e. interventions, treatments, aspirin, medications, surgery)? ______________________________

What have you tried that has **improved this problem**? ______________________________

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

_____ Burning _____ Stabbing _____ Aching _____ Sharp
_____ Tingling _____ Numb _____ Other: ______________

Please describe the location of the pain. ______________________________

Does this problem cause pain that travels to any other areas of the body? Y N If yes, where?

Please grade the severity of this problem (with 10 being worst):

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Now | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| On Average | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Is this problem: In the AM: ( ) worse? ( ) better?
In the PM: ( ) worse? ( ) better?

How often do you experience this problem? (Please Circle One)

<25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) >76% (Constant)

Have you seen any other doctors for this problem? Y N If yes, who? ______________________________



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Patient Name ______________________________ Date ____________

**Secondary Complaint** (*List one only*): ______________________________

When did you first experience this problem? ______________________________

How did this problem first begin? ______________________________

______________________________

What seems to aggravate this problem? ______________________________

What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, medications, surgery)? ______________________________

______________________________

What have you tried that has improved this problem? ______________________________

______________________________

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

_____ Burning _____ Stabbing _____ Aching _____ Sharp
_____ Tingling _____ Numb _____ Other: ______________

Please describe the location of the pain. ______________________________

______________________________

Does this problem cause pain that travels to any other areas of the body? Y N If yes, where?

______________________________

Please grade the severity of this problem (with 10 being worst):

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Now | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| On Average | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Is this problem: In the AM: ( ) worse? ( ) better?
In the PM: ( ) worse? ( ) better?

How often do you experience this problem? (Please Circle One)

<25% (Intermittent) 26-50% (Occasional) 51-75% (Frequent) >76% (Constant)

Have you seen any other doctors for this problem? Y N If yes, who? ______________

______________________________



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Patient Name ______________________________________ Date ________________

## Lifestyle/Social History

Job Description: ______________________________________

Work Schedule: ______________________________________

Recreational Activities: ______________________________________

| | | | |
|---|---|---|---|
| Do you smoke? | Y | N | If yes, how much? ______________________ |
| Do you drink alcohol? | Y | N | If yes, how much? ______________________ |
| Do you drink coffee? | Y | N | If yes, how much? ______________________ |
| Do you drink tea? | Y | N | If yes, how much? ______________________ |

| | | | | |
|---|---|---|---|---|
| Daily water intake: | ( ) None | ( ) 1-2 | ( ) 3-4 | ( ) 5+ |
| Daily servings of vegetables: | ( ) None | ( ) 1-2 | ( ) 3-4 | ( ) 5+ |
| Daily servings of fruits: | ( ) None | ( ) 1-2 | ( ) 3-4 | ( ) 5+ |
| How regularly do you exercise? | ( ) never | ( ) occasionally | ( ) ___x/week | ( ) daily |

What kind of exercise do you do? ______________________________________

How many hours of sleep do you get on average? ______________________________

What position do you regularly sleep in? Back Side Stomach

On a scale of 1-10 please rate your stress level (1=none and 10=extreme):

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Occupational | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Personal | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## Women Only

Pregnancies and outcomes:

| Date of pregnancy | Outcome |
|---|---|
| ______________ | ______________________________ |
| ______________ | ______________________________ |
| ______________ | ______________________________ |
| ______________ | ______________________________ |

When was your last period? ____________________

Are you pregnant? ( ) Yes ( ) No ( ) Not sure



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Patient Name ______________________________ Date ____________

# Medical History

Please list the cause of death (including cancer, heart disease, stroke or diabetes) and age of any immediate family members (parents or siblings):

| Relationship | Cause of Death | Age of death |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Surgeries:

| Date | Type | Reason for surgery |
|---|---|---|
| | | |
| | | |
| | | |

Previous injuries, trauma or fractures (please give type and date): ______________________________

______________________________________________________________

Medications (including over the counter drugs):

| Medication & Dosage | Reason for taking |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Nutritional Supplements you are currently taking:

| Supplement & Dosage | Reason for taking |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Allergies: ______________________________________________________________

______________________________________________________________



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Patient Name ______________________________________________ Date _______________

# Stress History

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

**Childhood**

| | | | | | |
|---|---|---|---|---|---|
| Repeated/Prolonged Antibiotic Use | Y | N | Inhaler Use | Y | N |
| Car Accident | Y | N | Prescription Medications | Y | N |
| Childhood Illness | Y | N | Surgery | Y | N |
| Fall/Jump from a Height < 3 feet | Y | N | Vaccinations | Y | N |
| Fall/Jump from a Height > 3 feet | Y | N | Youth Sports | Y | N |
| Head Trauma | Y | N | Other Traumas (physical or emotional) _____ | | |

_________________________________________

**Adulthood**

| | | | | | |
|---|---|---|---|---|---|
| Alcohol Consumption | Y | N | Inhaler Use | Y | N |
| Repeated/Prolonged Antibiotic Use | Y | N | Prescription Medications | Y | N |
| Car Accident | Y | N | Smoker | Y | N |
| Coffee Drinker | Y | N | Surgery | Y | N |
| Drug Use/Abuse | Y | N | Contact Sports | Y | N |
| Fall/Jump from a Height | Y | N | Extreme Sports | Y | N |
| Head Trauma | Y | N | Workplace Stress | Y | N |
| Home Environment Stress | Y | N | Other Traumas (physical or emotional) _____ | | |

_________________________________________

## Please CHECK AND EXPLAIN any of the following you have had in the last 12 MONTHS AND/OR EVER RECEIVED TREATMENT FOR:

**MUSCULO-SKELETAL: Check and Explain**

____Low Back Pain ____Pain Between Shoulders ____Neck Pain ____Arm Pain
____Joint Pain/Stiffness ____Walking Problems ____Difficult Chewing/Clicking Jaw ____General Stiffness

| Symptom | Date Last Experienced | Treatment Received |
|---|---|---|
| ____________ | ________________ | ______________________ |
| ____________ | ________________ | ______________________ |
| ____________ | ________________ | ______________________ |
| ____________ | ________________ | ______________________ |

**GENITO-URINARY: Check and Explain**

____Painful/Excessive Urination ____Discolored Urine ____Bladder Trouble

| Symptom | Date Last Experienced | Treatment Received |
|---|---|---|
| ____________ | ________________ | ______________________ |
| ____________ | ________________ | ______________________ |



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**CARDIO-VASCULAR- RESPIRATORY: Check and Explain**

____Chest Pain ____Short Breath ____Irregular Heartbeat ____Blood Pressure Problems
____Heart Problems ____Varicose Veins ____Ankle Swelling ____Stroke ____ Lung Problems/Congestion

| Symptom | Date Last Experienced | Treatment Received |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |

**NERVOUS SYSTEM: Check and Explain**

____Nervous ____Numbness ____Hearing Difficulty ____Forgetfulness ____Confusion/Depression
____Fainting ____Stress ____Dizziness ____Paralysis ____Cold/Tingling Extremities
____Convulsions

| Symptom | Date Last Experienced | Treatment Received |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |

**EYES, EARS, NOSE, THROAT: Check and Explain**

____Vision Problems ____Dental Problems ____Sore Throat ____Ear Aches ____Stuffed Nose

| Symptom | Date Last Experienced | Treatment Received |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |

**GENERAL: Check and Explain**

____Fatigue ____Allergies ____Headaches ____Fever

| Symptom | Date Last Experienced | Treatment Received |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |

**MALE / FEMALE: Check and Explain**

____Menstrual Irregularity ____Menstrual Cramps ____Vaginal Pain/Infection ____Breast Pain/Lumps
____Prostate/Sexual Dysfunction ____Other: ______________________

| Symptom | Date Last Experienced | Treatment Received |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |



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Patient Name ______________________________________________ Date ______________

**GASTRO-INTESTINAL: Check and Explain**

____Excessive Thirst ____Frequent Nausea ____Vomiting ____Black/Bloody Stools ____Poor/Excessive Appetite
____Constipation ____Hemorrhoids ____Colitis ____Liver Problems ____Gall Bladder Problems
____Weight Trouble ____Abdominal Cramps ____Diarrhea ____Heartburn ____Gas/Bloating after Meals

| Symptom | Date Last Experienced | Treatment Received |
|---|---|---|
| ________________ | ____________________ | ____________________________ |
| ________________ | ____________________ | ____________________________ |
| ________________ | ____________________ | ____________________________ |

**Please <u>check and explain</u> any of the following illnesses you have ever had:**

____Cancer ____Diabetes ____Mental Disorders ____Pneumonia ____Heart Disease
____Rheumatic Fever ____Small Pox ____Pleurisy ____Polio ____Chicken Pox
____Arthritis ____Tuberculosis ____Epilepsy ____Anemia ____Measles
____Whooping Cough ____Mumps ____Thyroid Disorder

| Symptom | Date Last Experienced | Treatment Received |
|---|---|---|
| ________________ | ____________________ | ____________________________ |
| ________________ | ____________________ | ____________________________ |
| ________________ | ____________________ | ____________________________ |
| ________________ | ____________________ | ____________________________ |

**Which best describes your reason for consulting our office?**

_____ I have a specific concern and require help with this concern.

_____ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

_____ I want to be healthier five years from now than I am today.

Patient's Signature ________________________________________ Date ______________



Doctor Initials:__________

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# Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and the "Chiropractor" refers to Dr. Tim Harrigan, D.C..

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment for me, obtaining payment for my healthcare bills or to conduct healthcare operations of Chiropractor. I understand that analysis, diagnosis, or treatment of me by Chiropractor may be conditional upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me; of there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Practices prior signing this document, if I requested one. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is available at the front desk of Synergy Wellness. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name of Patient ____________________________________________

Signature of Patient or Personal Representative ______________________________

Date of Signing ____________________



Doctor Initials:__________

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# TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment**
An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

**Health**
A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation**
A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another healthcare provider.

We do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, ______________________________________________ have read and fully understand the above statements. *(Print Name)*

**Consent to evaluate and adjust a minor child**
I, ______________________________________________________________ being the parent of legal guardian of ___________________________________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care. All questions regarding the doctor's objectives pertaining to my/ my child's care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian Signature _______________________________________ Date ________________



Doctor Initials:___________

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# Authorization to Release Medical Information

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature _______________________________________________ Date ________________

# Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY REPSONSIBLE FOR THE PAYMENT OF MY ACCOUNT.** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Patient Signature _______________________________________________ Date ________________

# E-Practice Form

In our never-ending quest to serve our practice members better, we are constantly updating our database and requesting current information. By providing this information it will allow you to take advantage of and have access to our on-line scheduling, online class/lecture registration and receive up to the minute information about all the events occurring with Dr. Tim Harrigan (including schedule changes, current events, and newsletters). This data will never be released to anyone! Our efforts are to provide you with unparalleled service. We look forward to continuing our tradition of exceeding all your expectations.

*Name*: ______________________________________________________________________

*E-Mail Address*: ______________________________________________________________



Doctor Initials:__________

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# NUTRITIONAL INFORMED CONSENT

Please be advised that any suggested nutritional or dietary advice that we may give you is not intended as primary treatment for any disease or particular bodily symptom.

Although Arizona law does not allow chiropractors to prescribe or administer medicine or drugs, chiropractors are allowed to provide nutritional counseling and advise and prescribe and sell nutritional products including, but not limited to, vitamins, minerals, water, enzymes, botanicals, homeopathic preparations, phytonutrients, glandular extracts, and natural hormones.

Nutritional counseling, vitamin recommendations, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in your diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Following our nutritional advice and suggested nutritional intake may also enhance the stabilization of the chemical components of the Subluxation Complex.

I, ________________________________ have read and understand the above:
Print Name

Signature:_______________________________ Date:___________________

# Supplement/Nutritional Product Refunds and Returns

In our efforts to provide the most fresh and best nutritional supplements available, we do not allow returns/refunds after 30 days of actual purchase date. There are many factors that contribute to preserving the quality and therapeutic properties of whole food nutritional products. In order to ensure that we are providing the freshest products to our patients, we have to enforce this policy as we can not reuse the products.

Signature:_______________________________ Date:___________________



Doctor Initials:__________

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# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

*We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.*

*There are several circumstances in which we may have to use or disclose your health information.*

- *We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.*
- *We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.*
- *We may need to use your health information within our practice for quality control or other operational purposes.*

*We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy for our privacy notices.*

*I authorized Synergy Wellness doctors and staff to contact me with information related to my personal health needs and interests. The physician's office may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:*

- *Appointment reminders or schedule changes.*
- *Information about alternative treatments, presentations or events*
- *Other health related information that may be of interest to me*

*To contact me, I authorize Synergy Wellness to use and disclose the following information:*

- *My Name, Address, Email and Phone Numbers*
- *The Name of my Physician and the Clinic where I was treated*

*NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.*

*Patient Name:* (PLEASE PRINT) *Date of Birth:*

*Address of Patient:* (STREET) *Phone:*

(CITY, STATE, ZIP CODE) *Email:*

*Synergy Wellness fully supports the protection of health information. Only the physician and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA, this authorization allows us to access only the above authorized information for contact purposes.*

*This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing to Synergy Wellness, Chiropractic, Nutrition, Weight Loss – 6015 E. Grant Rd., Tucson, AZ 85712. In this case, every effort will be made to discontinue future communications.*

Signature (PATIENT OR PERSON AUTHORIZED)________________________ Date________________________

Synergy Wellness
Dr. Tim Harrigan, Chiropractic Physician
6015 E. Grant Rd., Tucson, AZ 85712 – (520) 818-8857



Doctor Initials:___________