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 Address: _____

☐ Divorced ☐ Married ☐ Widowed City: _____ ST: _____ ZIP: _____

Home Telephone: (___) _____-_____ Work Phone: (_____) _____-_____

Mobile Telephone: (____) _____-_____ Employer: _____

Email: _____ Employer Address: _____

How did you hear of our office?: _____ City: _____ ST: _____ 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 are 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 credited 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 who 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 his/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's 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 indicate 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):

NO Pain ← → **WORST** Pain

0 1 2 3 4 5 6 7 8 9 10

		AT ***BEST***	ON ***AVERAGE***	AT ***WORST***
1.	_____			
2.	_____			
3.	_____			
4.	_____			

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

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? _____

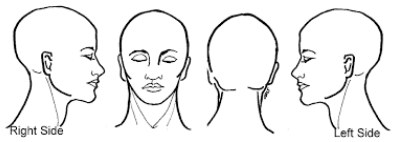
Is there anything that **EASES** your symptoms? ☐ No ☐ Yes → If "Yes," describe _____

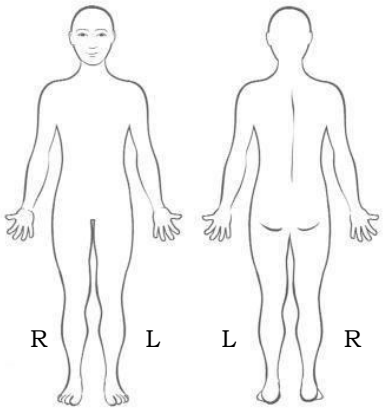
Do your symptoms **wake you up at night**? ☐ No ☐ Yes → If "Yes," describe _____

Are your symptoms **worse during any particular time of day**? ☐ No ☐ Yes → If "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 <u>for this condition</u>**? ☐ No ☐ Yes, a medical physician ☐ Yes, another chiropractor

Please List Anything Else That is of a Health Concern? _____

_____

_____

- All information is kept ***STRICTLY CONFIDENTIAL***. Please complete as accurately as possible. –

Name: _____ Date: _____

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

MUSULOSKELETAL 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
- ☐ Drug abuse
- ☐ Exercise

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

Doctor's Signature:

_____

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 ("HIPPA").

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

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 acknowledgement 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 collection fees.

_____

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

Synergy Chiropractic

6082 Limaburg Road
Burlington, KY 41005
(859) 647-6200

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