**Synergy Medical**
16705 Square Drive Marysville, Ohio 43040

**Patient Name**_____

**DOB:**_____ ▢ **Male** ▢ **Female**

Check appropriate box: ▢ Minor ▢ Single ▢ Married ▢ Divorced ▢ Widowed ▢ Separated

SS#/ SIN_____

Email_____ Home Phone_____ Cell Phone_____

Patient's Address_____ City_____ State_____ Zip_____

Employer Name_____

Spouse or Patients' Guardian Name_____ Spouse's Employer_____

How did you hear about us?_____

Emergency Contact_____ Phone_____

**Responsible Party**

Name of the person responsible for this account_____ Relationship to patient_____

Is the person currently a patient at our office? ▢ Yes ▢ No

Email_____ Home Phone_____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

Driver's License # _____ Date of Birth_____

**Do you have Medical Insurance?** ▢ Yes ▢ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Work Phone_____

Name of Employer_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ ID #_____ Group #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

*In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.*

_____ _____

Parent or Guardian Date

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS**
**AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS Y PERSONAL REPRESENTATIVE**
**AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Synergy Medical, Doctor Charita Cooper, Doctor Patrick Cooper, Alana Grabovich CNP, and Lindsay West, CNP** as well as all employees, employers, representatives, and agents thereof (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health Insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with the same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that the Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Providers. A photocopy or scan or this document is to be considered as valid as the original.

Signed this_____ day of _____, 20_____. X_____(SEAL)
(Patient signature)

X_____(SEAL) X_____
(Signature of Guardian if applicable) (Please print patient name)

**Health History**

**Chief Complaint**:_____

**History of Present Illness:**

**Location:**_____
*(Where is the Pain/ Problem?)*

**Quality**:_____
*(Example: Normal vs abnormal color, activity, etc..)*

**Severity:**_____
*(How severe is the pain/problem on a scale of 1-10 severe?)*

**Duration:**_____
*(How long have you had this pain/ problem? being the most When did it start?)*

**Timing**:_____
*(Does the pain/problem occur at a specific time?)*

**Context:**_____
*(Where were you at the onset of this pain/problem?)*

**Associated Signs/Symptoms:**_____
_____
_____
*(What other associated problems have you been having?)*

**Modifying Factors**:_____
*(What makes the pain/problem worse or better? Have you had previous episodes?)*

**Past Medical History**

*Have you ever had the following: (Please check all that apply)*

- ▢ Anemia
- ▢ Back Trouble
- ▢ Hepatitis
- ▢ Bladder Infection
- ▢ High Blood Pressure
- ▢ Ulcer
- ▢ Epilepsy
- ▢ Low Blood Pressure
- ▢ Kidney Disease
- ▢ Whooping Cough
- ▢ Migraine Headaches
- ▢ Hemorrhoids
- ▢ Scarlet Fever
- ▢ Tuberculosis
- ▢ Bleeding Tendency
- ▢ Diphtheria
- ▢ Diabetes
- ▢ Asthma
- ▢ Smallpox
- ▢ Cancer
- ▢ Hives or Eczema
- ▢ Pneumonia
- ▢ Polio
- Date of Last Chest X-Ray_____
- ▢ Rheumatic Fever
- ▢ Glaucoma
- *Any Other Disease, (Please List):*
- ▢ Arthritis
- ▢ Hernia
- _____
- ▢ Venereal Disease
- ▢ Mitral Valve Prolepses
- _____
- ▢Stroke Chronic Bronchitis
- ▢ Infectious Mono AIDS & HIV

| **Previous Hospitalizations/ Surgeries/Serious Illnesses** | When? | Hospital, City, State |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Medication:** *(include non prescription)*

_____

_____

**Drug Allergies, including reaction to them:**

_____

_____

**Sleep:**

Average length of sleep (hours):_____

Does pain affect sleep? ▢ NO ▢ YES

How many pillows do you sleep with? 1 2 3 4

Energy level: ▢ Low ▢ Moderate ▢ Adequate

How has your mood been lately? _____

**Patient Social History:**

Use of Alcohol: ▢ Never ▢ Rarely▢ Moderate ▢ Daily

Use of Tobacco: ▢ Never ▢ Rarely▢ Moderate ▢ Daily

Use of Drugs: ▢ Never Type/Frequency:_____

Excessive Exposure At home or at work to: ▢ Fumes ▢ Dust ▢ Solvents ▢ Airborne Particles ▢ Noise

**Family Medical History:**

| | Age | Disease | If Deceased, Cause Of Death |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Sibling's | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Spouse | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

**Eyes/Ears/Nose/Throat/Respiratory**

| | |
|---|---|
| Asthma | 1 2 3 4 5 |
| Stuffy Nose | 1 2 3 4 5 |
| Hay Fever | 1 2 3 4 5 |
| Itching | 1 2 3 4 5 |
| Chronic Cough | 1 2 3 4 5 |
| Chest Congestion | 1 2 3 4 5 |
| Shortness of Breath | 1 2 3 4 5 |
| Wheezing | 1 2 3 4 5 |

**Muscular/Skeletal**

| | |
|---|---|
| Muscle Aches | 1 2 3 4 5 |
| Fibromyalgia | 1 2 3 4 5 |
| Arthritis | 1 2 3 4 5 |
| Joint Pain | 1 2 3 4 5 |
| Low Back Pain | 1 2 3 4 5 |
| Neck Pain | 1 2 3 4 5 |
| Wrist/Hand Pain | 1 2 3 4 5 |
| Elbow Pain | 1 2 3 4 5 |
| Shoulder Pain | 1 2 3 4 5 |
| Hip Pain | 1 2 3 4 5 |
| Knee Pain | 1 2 3 4 5 |
| Ankle/Foot Pain | 1 2 3 4 5 |
| Pain b/t shoulder blades | 1 2 3 4 5 |
| Muscle Spasm | 1 2 3 4 5 |

**Neurological**

| | |
|---|---|
| Headaches | 1 2 3 4 5 |
| Migraines | 1 2 3 4 5 |
| Dizziness | 1 2 3 4 5 |
| Numbness | 1 2 3 4 5 |
| Tingling | 1 2 3 4 5 |
| Pins/needles in hands/feet | 1 2 3 4 5 |
| Recent Vision Changes | 1 2 3 4 5 |
| Loss of Consciousness | 1 2 3 4 5 |

**General**

| | |
|---|---|
| Fatigue | 1 2 3 4 5 |
| Malaise | 1 2 3 4 5 |
| Weakness, tiredness | 1 2 3 4 5 |
| Lightheadedness | 1 2 3 4 5 |
| Irritability | 1 2 3 4 5 |
| Constipation | 1 2 3 4 5 |
| Diarrhea | 1 2 3 4 5 |
| Feeling foggy | 1 2 3 4 5 |
| Forgetfulness | 1 2 3 4 5 |
| Insomnia/difficult sleeping | 1 2 3 4 5 |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

*Signature of the Patient, Parent or Guardian* *Date*

Provider's Review

_____ _____

*Signature of Provider* *Date*

# CONSENT TO TREAT

**The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read below and if you have any questions, please feel free to ask.**

## AUTHORIZATION TO GIVE MEDICAL CARE-CONSENT TO TREATMENT:

I hereby voluntarily consent to outpatient care from Synergy Medical encompassing routine diagnostic procedures, physical examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications prescribed by the providers (joint injections, PRP, trigger point injections, regenerative cell medicine). I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Synergy Medical's medical providers and staff, as is necessary in the medical staff's judgement. I understand that during the course of treatment, health care workers may be exposed to the patient's blood and/or body fluids increasing the risk of contracting Hepatitis B, Hepatitis C and/or HIV. In the event that exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the healthcare worker. I understand that this consent will be valid and will remain in effect as long as I attend the clinic. Please see below for potential risks and side effects.

- Injection: increased pain or discomfort, infection, allergic reactions, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, hematoma formation, collapsed lung, seizures, even remote risk of death or serious disability that exist with any surgical procedure.
- Blood Draw: increased pain or discomfort, infection, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, or hematoma formation.
- Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.
- Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.
- Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

### Consent to Evaluate and Treat a Minor:

I, _____being the parent or legal guardian of _____, have read and fully understand the above terms and hereby grant permission for my child to receive treatment with Synergy Medical.

## Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

[ ] No One [ ] Name/Relationship: _____ Phone: _____

May we leave messages regarding your personal healthcare information on an answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

## Acknowledgment

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Patient Print Name: _____Signature: _____ Date: _____

Witness Name Print: _____ Signature:_____ Date:_____

**Women Only:**

To the best of my knowledge, **I am/am NOT** pregnant and (**give my permission/don't give my permission**) to x-ray me for diagnostic interpretation.

## Protecting Your Health Information

### New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individuals and medical records.

### Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need the record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

### Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will be entering your name and email into our database.

### Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

### Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may include anything concerning the primary health care of that patient.

### Notification by Mail or Phone

Patients may be contacted by mail, email, or phone unless written notification is requested that contact be only in person.

### Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Patient/Guardian Signature:_____Date:_____

# PHOTO/VIDEO RELEASE FORM

Permission to Use Photograph/Video

I grant Synergy Medical, its representatives and employees the right to take photographs of me and my property in connection with the above identified subject. I authorize Synergy Medical , its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Synergy Medical may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature_____

Printed Name_____

Date_____

Signature, parent or guardian_____

(If under age 18)

**MECHANISM OF INJURY:**

The injury was due to:_____ Date of accident:_____

**FOR WORKMAN'S COMPENSATION- RELATED VISITS ONLY:**

How did the injury occur? Check all that apply.

▢ Bending ▢ Carrying ▢ Climbing ▢ Crawling
▢ Driving (Driver) ▢ Driving (Passenger) ▢ Job Activity ▢ Jumping
▢ Kneeling ▢ Raising arm(s) above shoulder(s) ▢ Repetitive motion ▢ Running
▢ Sitting ▢ Squatting ▢ Standing ▢ Standing from a seated position
▢ Traveling (Public Trans) ▢Turning ▢ Twisting ▢ Typing
▢ Using Computer ▢ Walking ▢ Other:_____

**FOR PEDESTRIAN ACCIDENTS ONLY:**

As a pedestrian, what were you (or the patient) doing at the time of the accident?_____

**FOR AUTO ACCIDENTS ONLY:**

Were you (or the patient) wearing a seatbelt? ▢ Yes ▢ No ▢ Don't know
Did the airbag deploy? ▢ Yes ▢ No
Where in the vehicle were you (or the patient) when the accident happened?_____
What interior vehicle part did you (or the patient) come into contact with? Check all that apply.

▢ Airbag ▢ Armrest ▢ Dashboard ▢ Door ▢ Flying object(s) inside vehicle ▢ Headrest
▢ Seat ▢ Window ▢ Windshield ▢ Steering wheel
▢ No Interior parts were contacted at time of accident

**FOR MOTORCYCLE/BICYCLE ACCIDENTS ONLY:**

Where on the vehíchle were you (or the patient) when the accident happened? ▢ Operator ▢ Passenger
What type of protection did you (or did the patient) have? Check all that apply.

▢ Bicycle helmet ▢ Motorcycle Helmet- full face ▢ Motorcycle Helmet- half face
▢Motorcycle Helmet- open face ▢ Protective eyewear ▢ Leather
▢ Gloves ▢ Boots ▢ No Protective wear
▢ Other:_____

What did you (or the patient) come into contact with at the time of the collision?_____
Where were you (or the patient) looking at the time of impact? _____

**FOR ALL VEHICLE RELATED ACCIDENTS:**

Did you (or the patient) come in contact with anything at the time of the collision? ▢ Yes ▢ No ▢ Don't know
Don't know What part of you (or the patient's) body made contact? Check all that apply.

▢ None made contact ▢ Back of head/neck ▢ Front of head ▢ Left arm ▢ Left Chest/flank
▢ Left head ▢ Left Knee ▢ Left shoulder ▢ Left leg ▢ Right arm
▢ Right Chest/flank ▢ Right head ▢ Right Knee ▢ Right leg ▢ Left shoulder
▢ Other:_____

Did you (or the patient) receive an injury to the head? ▢ Yes ▢ No
Did you (or the patient) lose consciousness*?* ▢ Yes ▢ No
What part of your (or the patient's) vehicle was impacted? Check all that apply.

▢ Front right ▢ Front left ▢ Front head on ▢ Rear right ▢ Rear left ▢ Rear end
▢ Right side (passenger side) ▢ Left side (Drivers side) ▢ Unknown

In what direction was your (or the patient's) vehicle moving?_____
What was the estimated speed of your (or the patient's) vehicle? _____
What was the extent of the damage to you (or the patients) vehicle?_____
What was the extent of the damage to the other vehicle?_____
In what direction was the other vehicle moving?_____
What was the estimated speed of the other vehicle?_____
Was your (or the patient's) vehicle towed from the scene? ▢ Yes ▢ No
Did police arrive at the scene? ▢ Yes ▢ No

Did Emergency Medical Services arrive at the scene? ▢ Yes ▢ No

Was an accident report taken? ▢ Yes ▢ No

**FOR ALL ACCIDENTS AND INJURIES:**

Were you (or was the patient) transported to a medical facility (ER or hospital)?_____

Have you (or has the patient) received any treatment since the accident? Check all that apply.

▢ Admitted ▢ Examinations was performed ▢ Home treatment - cold

▢ Hometreatment - heat ▢ Hometreatment - over-the-counter medication

▢ Hometreatment - rest ▢ Medication was prescribed ▢ Physical therapy

▢ Referred to orthopedics ▢ Referred to chiropractor ▢ Referred to neurologists ▢ Referred to orthopedics ▢ Surgery ▢ Released ▢ Referred for further evaluation and treatment ▢ Released that day

▢ Referred to primary care provider ▢ X rays were completed

▢ No treatment since accident ▢ Other:_____

What was the location of symptoms felt at the time of the accident? Check all that apply.

Head: ▢ Front ▢ Back ▢ Right side ▢ Left side

Neck: ▢ Front ▢ Back ▢ Right side ▢ Left side of neck

Back: ▢Right mid ▢Left mid ▢Central mid ▢Right low ▢ Left low ▢ Central low

Trunk: ▢Abdomen ▢ Chest ▢ Front - ribs ▢ Back - ribs ▢ Right side- ribs ▢ Left side- ribs

Upper Extremity:

▢ Front, right shoulder ▢ Rear, right shoulder ▢ Front, left shoulder ▢ Rear, left shoulder

▢ Front, right upper arm ▢ Rear, right upper arm ▢ Front, left upper arm ▢ Rear, left upper arm

▢ Front, right forearm ▢ Rear, right forearm ▢ Front, left forearm ▢ Rear, left forearm

▢ Front, right elbow ▢ Rear, right elbow ▢ Front, left elbow ▢ Rear, left elbow

▢ Front, right wrist ▢ Rear, right wrist ▢ Front, left wrist ▢ Rear, left wrist

▢ Front, right hand ▢ Rear, right hand ▢ Front, left hand ▢ Rear, left hand

Lower Extremity:

▢ Front, right hip ▢ Rear, right hip ▢ Front, left hip ▢ Rear, left hip

▢ Front, right thigh ▢ Rear, right thigh ▢ Front, left thigh ▢ Rear, left thigh

▢ Front, right knee ▢ Rear, right knee ▢ Front, left knee ▢ Rear, left knee

▢ Front, right leg ▢ Rear, right leg ▢ Front, left leg ▢ Rear, left leg

▢ Front, right ankle ▢ Rear, right ankle ▢ Front, left ankle ▢ Rear, left ankle

▢ Top, Right foot ▢ Bottom, right foot ▢ Right side, right foot ▢ Left side, right foot

▢ Top, left foot ▢ Bottom, left foot ▢ Right side, left foot ▢ Left side, left foot

▢ Other:_____

Describe the discomfort felt at the time of the accident. Choose all that apply.

▢Aching ▢ Burning ▢ Deep ▢ Diffuse ▢ Dull ▢ Heavy ▢ Numbness ▢Pulling

▢ Sharp ▢ Shock Like ▢ Shooting ▢Stiffness ▢ Throbbing ▢ Tightness ▢ Tingling ▢ Other

Are there any additional symptoms which appeared since the accident happened? Check all that apply.

▢ Anxiety ▢ Breathing difficulty ▢ Chest pain ▢ Depression ▢ Disbelief

▢ Dizziness ▢ Exhaustion ▢ Facial pain ▢ Genital pain ▢ Gluteal pain

▢ Headaches ▢ Irritability ▢ Loss of appetite ▢ Low energy ▢ Muscle spasm

▢ Numbness and tingling ▢ Rib pain ▢ Shock ▢Sleeping difficulty

▢ Soreness ▢ Stomach pain ▢ Stress ▢ Tightness ▢ Tiredness

▢ Other:_____ ▢ None

Describe the status of your symptoms since the accident. Check all that apply.

▢ Disappeared ▢ Elicited less stiffness ▢ Elicited more stiffness

▢ Elicited less pain ▢ Elicited more pain ▢ Improved ▢ Exacerbated

▢ Stayed the same ▢ Somewhat resolved ▢ Lessened ▢ Worsened

▢ Worsened quality of life ▢ Shown no change in daily functioning at home/work

▢ Improved daily functioning at home/work ▢ Deteriorated daily functioning at home/ work

▢ Other:_____

**GOALS FOR YOUR CARE:**

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor wiLl weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ▢ I want the Doctor to select the type of care appropriate for my condition.
- ▢ Relief care: Symptomatic relief pain or discomfort
- ▢ Corrective care: Correcting and relieving the cause of the problem as well as the symptoms
- ▢ Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic care

**WORKER'S COMPENSATION:**

Who saw the accident:_____ Title:_____

Who reported the accident:_____ Title:_____

Type of windows:_____ Type of shop:_____

Do you use hand or foot levers? ▢ Yes ▢ No Do you work overhead? ▢ Yes ▢ No

Are you tired when you go home? ▢ Yes ▢ No

Describe the accident:

_____

_____

_____

Do you lift from? ▢ Ground ▢ Bench ▢ Platform What are you lifting? ▢ Box ▢ Pallet ▢ Other

Do you have to reach? ▢ Yes ▢ No Explain:_____

Is your work area cluttered? ▢ Yes ▢ No Explain:_____

Do you push or pull? ▢ Yes ▢ No Explain:_____

Do you pick up or lift ▢ Yes ▢ No How much?_____ How often?_____

Do you lift in and out of a machine? ▢ Yes ▢ No If so, do you: ▢ Sit ▢ Stand ▢ Kneel

Type of floor: ▢ Rough ▢ Smooth ▢ Wood ▢ Concrete ▢ Steel ▢ Other:_____

Type of ventilation: ▢ Blower ▢ Heat ▢ Exhaust ▢ None ▢ Other:_____

Type of lighting: ▢ Flourescent ▢ Overhead ▢ On Machine ▢ Other:_____

Is your work ares: ▢ Oily ▢ Dirty ▢ Slippery ▢ Other:_____

Do you have any other jobs? ▢ Yes ▢ No If yes, what type?_____

Has outside help been hired? ▢ Yes ▢ No If yes, why?_____

Do you use a cart? ▢ Yes ▢ No Type of wheels: ▢ Rubber ▢Steel ▢ Plastic

Condition of cart: ▢ Good ▢ Bad ▢ Other:_____

# of carts being moved at once:_____ Weight moved per day:_____

From where to where:_____

**Synergy Medical**
16705 Square Drive Marysville, Ohio 43040

# ATTORNEY'S WE RECOMMEND FOR WORKERS COMP

Willis and Willis, Atty At Law
4653 Trueman Blvd #100
Hillard, Ohio 43026
614-586-7900

Cannizzaro, Bridges, Jillinsky & Streng LLC
302 S. Main
Marysville, Ohio 43040
937-303-4165


**Alana Grabovich, CNP ● Lindsay West, CNP ● Charita N.Cooper, DC CACCP ● Patrick S. Cooper, DC CCEP**

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my primary care physician of my condition, treatment and expected/actual response to care at this office.

Patient/Guardian Signature:_____

Name (Please Print):_____

Primary Care Physician:_____

Physician's Address/Phone:_____

_____