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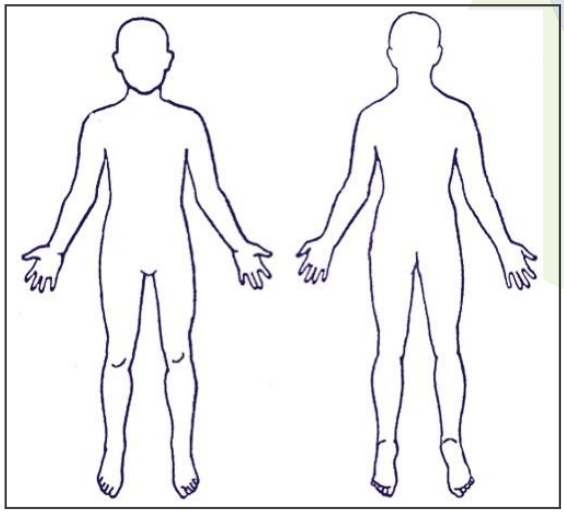
Patient History

Please mark (x) on the diagram below where you are feeling pain.



Patient Name: _____

Date of Birth_____/_____/_____ **Height**

_____**Weight** _____

Referring Provider _____

CHIEF COMPLAINT:

What is bothering you? Which areas of your body are affected?

_____

_____

_____

QUALITY OF PAIN: Circle the quality of pain you have experienced on average for the past month:

INTENSITY: Excruciating Severe Moderate Mild Noticeable None

% of the Day: Occasional 0-25% Periodic 26-50% Frequent 51-75% Constant 76-100%

SENSATION: Piercing Stabbing Shooting Burning Throbbing Cramping
Aching Stinging Squeezing Numbing Tingling None

SEVERITY: Indicate the number that best describes your pain level: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain

DURATION/TIMING/AGGRAVATING & ALLEVIATING FACTORS:

How long have you had your symptoms (in months and years)? _____

What caused the symptoms to start? _____

How often do you have your symptoms? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

What treatments have you tried to treat your symptoms: ☐Chiropractic ☐Medication ☐Injections ☐PT ☐Massage
☐ Acupuncture ☐Heat ☐Ice ☐Other _____

What medications have you tried to treat your symptoms? _____

INITIAL TREATMENT GOAL: What would you like to achieve from treatments? _____

What treatments are you interested in trying? ☐Chiropractic ☐Medication ☐Injections ☐PT ☐Massage ☐ Acupuncture

ALLERGIES (please include reaction)**:** _____

MEDICATIONS (Include all over-the-counter and supplements):

	Medication Name	Strength/How often		Medication Name	Strength/How often
1.	_____	_____	5.	_____	_____
2.	_____	_____	6.	_____	_____
3.	_____	_____	7.	_____	_____
4.	_____	_____	8.	_____	_____

13020 Livingston Rd, Suite 14
Naples, FL 34105

239-263-3330
www.synergynaples.com

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Patient History

Have you ever had previous chiropractic care? ☐Yes ☐No

Type of Adjustments preferred: Diversified (Popping Sound) Mobilization (noiseless)
Activator or Instrument Adjustment ☐Thompson Drop Other:_____

Therapies that have helped in the past: ☐Adjustment ☐Massage ☐Electric Stim ☐Medications ☐Injections ☐Acupuncture ☐Physical Therapy

Mattress Age:_____ Sleep Position: ☐Side ☐Back ☐Stomach ☐All

Activity: ☐Sedentary ☐Light ☐Active ☐Very ☐Active

REVIEW OF SYMPTOMS: *Have you experienced any of the following in the past month? Circle all that apply:*

CONSTITUTIONAL: *Weakness, Fatigue, Weight Loss/Gain, Chills, Night Sweats, Fevers*

HEENT: *Headaches, Eye Pain, Decreased Hearing, Earache, Changes in Vision, Changes in Speech, Nasal Discharge*

CARDIOVASCULAR: *Chest Pain, Palpitations, Chest Pressure, Swelling of Legs/Feet, Demand Pacemaker, Defibrillator*

RESPIRATORY: *Persistent Cough, Shortness of Breath, Difficulty Breathing, Wheezing, TB Infection/Exposure*

ABDOMINAL: *Reflux, Nausea, Vomiting, Abdominal Pain, Diarrhea, Constipation, Blood in Stool, Fecal Soiling*

GENITOURINARY: *Urinary Frequency, Urinary Urgency, Blood in Urine, Bladder Incontinence*

NEUROLOGIC: *Numbness, Tingling, Weakness, Dizziness, Imbalance, Difficulty Walking, Fainting, Unsteady Gait*

PSYCHIATRIC: *Depression, Anxiety, Insomnia*

INTEGUMENTARY: *Easy bleeding/Bruising, Lumps/Bumps, Non-Healing Wounds*

MUSCULOSKELETAL: *Limb pain, Muscle Aches, Muscle Spasm, Joint Swelling, Joint Pain, Neck Pain, Hand/ Wrist Pain, Elbow Pain, Shoulder Pain, Mid-Back Pain, Low-Back Pain, Hip Pain, Knee Pain, Ankle Pain, Foot Pain*

ENDOCRINE: *Heat, Intolerance, Cold Intolerance, Changes in Appetite, Changes in Thirst*

HEME/ LYMPH: *Easy Bruising, Easy Bleeding, Swollen Glands*

ALLERGIC/ IMMUNE: *Autoimmune Disease, Communicable Disease*

MEDICAL HISTORY *Check box if you have a personal history of any of the following:*

- ☐ Atrial Fibrillation
- ☐ Asthma
- ☐ Allergies
- ☐ Anemia
- ☐ Bleeding
- ☐ Breast Cancer
- ☐ Bladder Cancer
- ☐ BPH
- ☐ Inflammatory Bowel Disorder
- ☐ Colon Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ DVT
- ☐ Drug/ Alcohol Abuse
- ☐ Epilepsy
- ☐ Gout
- ☐ Glaucoma
- ☐ GERD
- ☐ Gastric Ulcers
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Heart Disease
- ☐ Fibromyalgia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Leukemia
- ☐ Lupus
- ☐ Macular Degeneration
- ☐ Nephrolithiasis
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis/ Osteopenia
- ☐ Prostate Cancer
- ☐ Polymyalgia Rheumatica PMR
- ☐ Parkinson's Disease
- ☐ Prior MI
- ☐ Peripheral Vascular Disease
- ☐ Renal Disorder
- ☐ Rhythm Disorder
- ☐ Rheumatoid Arthritis
- ☐ Skin Cancer
- ☐ Stroke
- ☐ Syphilis
- ☐ Seizure Disorder
- ☐ Thrombocytopenia
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Vitamin Deficiency
- ☐ Other: _____

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Patient History

MEDICAL HISTORY *Continued:*

Do you have a demand pacemaker, cardiac defibrillator or implantable stimulator? ☐Yes ☐No

If Yes, Please Explain_____

Have you had any diagnostic studies? ☐MRI ☐ Xray ☐CT Scan ☐ NCV ☐Diagnostic Ultrasound

If yes, please list area and date: _____

Past Surgical History: (Procedure and Date) _____

_____

_____

FAMILY HISTORY: Circle all that apply

Significant for: Diabetes; Cancer; Heart Disease; Unobtainable/Adopted

Maternal: (Alive; Deceased) Cause of death:_____

Paternal (Alive; Deceased) Cause of death:_____

Number of Siblings:_____Significant Medical Illnesses: _____

WOMEN: Are you currently pregnant or plan on becoming pregnant? ☐Yes ☐No

SOCIAL HISTORY:

Current or history of drug use? ☐Yes ☐No If yes, please explain: _____

Current or history of alcohol use? ☐Yes ☐No Drinks per day_____Year Quit _____

Current or history of tobacco use? ☐Yes ☐No Packs per Day_____Year Quit_____

Current or history of caffeine use? ☐Yes ☐No Drinks per day_____Year Quit _____

Present living situation? ☐Alone ☐With Spouse ☐With Children ☐With Parents ☐With Other: _____

Marital History: ☐Married ☐Divorced ☐Widowed ☐Single

EDUCATION: ☐Some H.S. ☐High School ☐Some College ☐College Graduate ☐Advanced Degree

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 authorize the healthcare staff to perform the necessary healthcare services I may need.

Signature:_____

Date: _____

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Patient History

GENERAL INFORMATION

Patient: Last Name:_____First Name: _____

Address:_____

City, State and Zip Code: _____

Home Phone (_____)_____Cell Phone: (_____)_____ Work

Phone (_____)_____Email Address: _____

Out of State Address: _____

Date of Birth:_____/_____/_____Age:_____Social Security #:____-____-_____Sex: ☐Male ☐Female

Appointment reminders: ☐Email ☐Text ☐Business Card

Emergency Contact: _____

Emergency Contact Phone #: (_____)_____Relationship:_____

Whom may we thank for referring you to us? _____

Employment: ☐Full Time ☐Part Time ☐Retired ☐ Not Employed

Patient's Employer: _____

Address:_____

Phone Number: (_____)_____Occupation: _____

Will you be using insurance today? ☐Self Pay ☐Health Insurance ☐Other

:

INSURANCE INFORMATION

Primary Insurance Company Name: _____

Membership #:_____Group #: _____

Secondary Insurance Company Name: _____

Membership #:_____Group # : _____

AUTO ACCIDENT/WORKERS' COMPENSATION ONLY

Insurance Company Name:_____Claim #: _____

Adjustor's Name:_____Phone Number: (_____)_____

Attorney's Name:_____Phone Number: (_____)_____

Preferred Language:_____ ☐ Prefer not to say

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Patient Financial Agreement

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ Date of Birth:_____

Home Phone: _____ Work Phone: _____

Address: _____

City/State/Zip:_____

The above listed patient authorizes the following healthcare facility to make healthcare disclosure

Facility Name:_____ Facility Phone:_____

Facility Address:_____

City/State/Zip:_____

Dates and type of information to disclose:

2 years prior from last date seen

Dates other:_____

Specific information requested:_____

Reason for disclosure:

Change of insurance or physician

Continuation/continuity of care

Referral

Other:_____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:
Release To: Synergy Health Center Please Mail Records Please Fax Records
Address: 13020 Livingston Road, Suite 14, Naples, FL 34105, Fax: 239-263-7492 Phone: 239-263-3330

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information in voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative — Date

_____ _____

Name of Authorized Representative — Date

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Patient Financial Agreement

CONSENT TO TREAT

This consent provides us with your permission to perform reasonable and necessary medical/chiropractic/physical therapy examinations, testing and treatment by the following staff: Dr. Stephanie Ahasic, DC; Dr. Benjamin Mendelsohn, MD; Dr. Christopher Ellis, DPT or Kara Corona, ARNP. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. This notice will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You also have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test or procedure recommended for you. If you have any questions or concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I have had the opportunity to discuss with the treating provider the nature and purpose of treatment and other procedures. I voluntarily request any of the above listed providers at Synergy Health to perform reasonable and necessary medical examinations, testing or treatment for the condition(s) which have brought me to seek care at Synergy Health. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including ,but not limited to fractures, disc injuries, strokes, dislocations and sprains. These risks are rare and unlikely. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, in my best interest.

I have read, and or have had read to me, the above consent. I have also had a opportunity to ask questions about its content. By signing below, I agree to the above-named procedures. I intend this consent form to cover the entire core of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (LC417A)

Disclosure of medical information: Your medical information and communication of that information is essential to your care. We prefer to speak with each patient directly but we understand that other individuals or family members may have knowledge of our be assisting in your care. Please list the individuals with whom we are allowed to discuss any aspect of your care. We can NOT discuss medical information with others including spouses or relative unless they are listed below.

Name of contact and relationship to patient: _____ Phone #: _____

Name of contact and relationship to patient: _____ Phone #: _____

Name of contact and relationship to patient: _____ Phone #: _____

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICE (NPP)

I understand that Synergy Health Center may share my Protected Health Information, (PHI) for treatment, payment and healthcare operations, (TPO), and for other purposes provided by law. I have been provided a copy of Synergy Health Center's Notice of Privacy Practices that describes how my Protected Health Information is used and shared. I understand the Synergy Health Center has the right to change this nocie at nay time. I may obtain a current copy by contacting Synergy Health Center at 239-263-3330. My signature below constitutes my acknowledgement and that I have been provided with a copy of this notice of privacy practice.

Patient Signature: _____ Date: _____

Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Synergy Integrated Healthcare/Synergy Chiropractic Health for medical supplies and/or medication(s) furnished to me by Synergy Integrated Healthcare/Synergy Chiropractic Health.

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

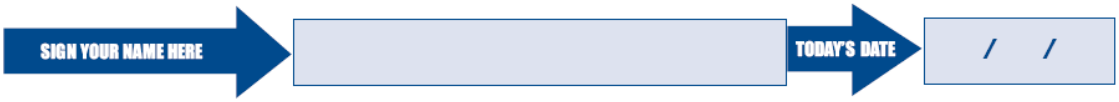
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. Synergy Integrated Healthcare/Synergy Chiropractic Health to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and/or medication(s) provided.

5. Synergy Integrated Healthcare/Synergy Chiropractic Health to contact me by telephone or mail regarding my medical supplies and/or medication(s) order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # ( )



I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Synergy Integrated Healthcare/Synergy Chiropractic Health for any medical supplies and/or medications furnished to me by Synergy Integrated Healthcare/Synergy Chiropractic Health. I authorize any holder of medical information about me to release to Synergy Integrated Healthcare/Synergy Chiropractic Health, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

I _____ appoint _____ to act as
(name of beneficiary) (name of representative)
my personal representative with Medicare, Medicaid or private insurance.

Their relationship to me is spouse, child, parent, sibling, other _____.
(choose one) (or write in)

The reason I cannot sign is: _____.
(list reason)

My representative does or does not live with me. (choose one)
If not, their address and phone number is:
Address: _____ Phone: _____

City/St/Zip: _____

Signature: _____ Date: _____
My signature and date above authorizes the above named person to sign on my behalf.