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# PATIENT HISTORY

Patient Name:

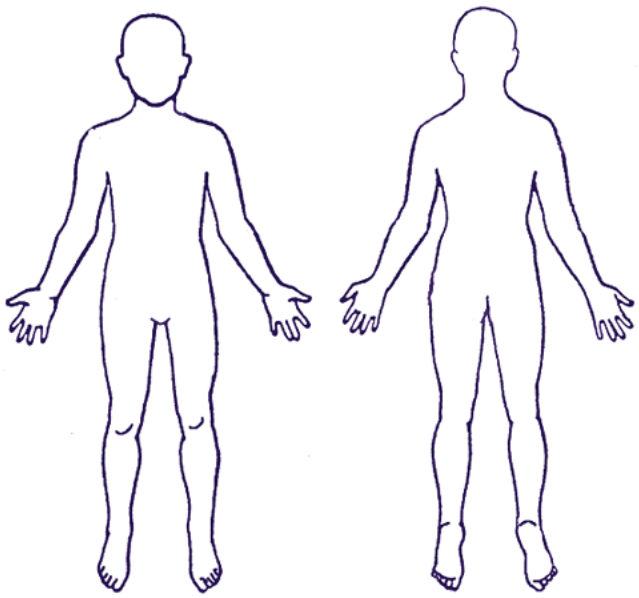
Date of birth:

Height:

Weight:

Referring Provider:

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



## CHIEF COMPLAINT

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

## QUALITY OF PAIN

*Check the quality of pain you have experienced on average for the past month*

**INTENSITY:** Excruciating ☐ Severe ☐ Moderate ☐ Mild ☐ Noticeable ☐ None ☐

**% of the day:** Occasionally 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*

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# PATIENT HISTORY

## 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 ☐ Acupunture ☐ Heat ☐
Ice ☐ ☐ Other

What medication have you tried to treat your symptoms?

## INITIAL TREATMENT GOAL

What would you like to achieve from treatment?

What treatment are you interested in trying?

Chiropractic ☐ Medication ☐ Injections ☐ PT ☐ Massage ☐ Acupunture ☐

**ALLERGIES** (please include reaction):

## MEDICATIONS (include all over-the-counter and supplements):

| | Medication Name | Strength / How Often |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |

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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 ☐ Active ☐ Very Active

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

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

**HEENT:** ☐ Headaches ☐ Eye Pain ☐ Decreased Hearing ☐ Ear ache ☐ 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

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# PATIENT HISTORY

## MEDICAL HISTORY

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

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

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)

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# PATIENT HISTORY

**FAMILY HISTORY:** Check 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 ○ 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 Others

Present living situation?

☐ Married ☐ Divorced ☐ Widowed ☐ Single

## EDUCATION

☐ Some H.S. ☐ High School ☐ Some College ☐ College Graduate

☐ Advanced Degree

Occupation

Employer

☐ Not Working ☐ Retired

*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 | Zip Code

Home Phone | Cell Phone | Work Phone

Email Address: | Out of State Addresss:

Date of Birth | Age | Social Security

Sex: Male ☐ Female ☐ Other ☐

Appointment reminders: ☐ Email ☐ Text ☐ Business Card

Emergency Contact: | Emergency Contact Phone: | Relationship:

Whom may we thank for referring you to us?

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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# RECORDS REQUEST

## RECORDS REQUEST

Patient Name

Date of Birth

Address

City

State

Zip Code

Home Phone

Work Phone:

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

Facility Name

Facility Phone

Facility Address

City

State

Zip Code

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 immuno deficiency syndrome (AIDS), or human immuno deficiency 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 anytime. 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 insurerwith the right to contesta claim undermy. policy. Unless otherwise revoked, this authorization wi ll expi re 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 red is closure 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 fore going Authorization for Release of Information and do hereby acknowledge that I am familiar with fully understand the terms and conditions of this authorization.

Signature of Patient/Parent/Guardian or Authorized Representative

Date

Name of Authorized Representative

Date

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# PATIENT HISTORY

## CONSENT OF TREAT

This consent provides uswith your permission to perform reasonable and necessary medical/chiropractic/physical therapy examinations, testing and treatment by the following staff: Dr. StephanieAhasic, DC; Dr. Benjamin Mendelsohn, MD; Dr. Laurie MacKinnon; Lindsay Benezra, PTA, Dr. Luke Schaefer, DPT. or J. Brianne Cummings, 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 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 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 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, 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

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 SynergyHealth Center's Notice of Privacy Practices that describes howmy Protected Health Information is used and shared. I understand the Synergy Health Center has the right to change this notice at aytime. 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.

_____ _____

Parent/Signature Date

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PATIENT HISTORY

# Assignment of Benefits (A0B)

**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 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 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.***

Phone Number

Signature

Date