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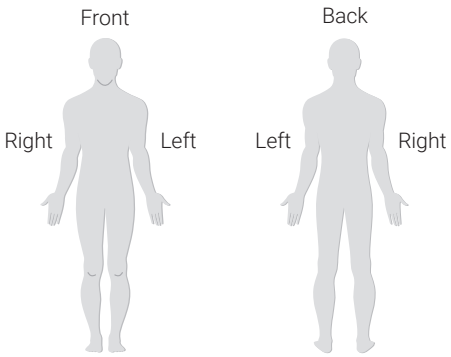
CHIEF COMPLAINT

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



- **Please identify the area of pain by selecting the side of the body that is effected:**

R = Right L = Left *Circle All That Apply*

Neck Pain	R	L	Wrist Pain	R	L
Mid Back Pain	R	L	Hand Pain	R	L
Low Back Pain	R	L	Hip Pain	R	L
Shoulder Pain	R	L	Knee Pain	R	L
Elbow Pain	R	L	Foot/Ankle Pain	R	L

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%
- ☐ Night Pain

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

SEVERITY:

Indicate the number that best describes your pain level.

1 2 3 4 5 6 7 8 9 10

NO PAIN 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?**
  - ☐ Sitting
  - ☐ Activity
  - ☐ Standing
  - ☐ Rest
  - ☐ Sleep Position
  - ☐ Other: _____
- **What makes your symptoms better?**
  - ☐ Sitting
  - ☐ Activity
  - ☐ Standing
  - ☐ Rest
  - ☐ Sleep Position
  - ☐ Other: _____
- **Sleep Position:**
  - ☐ Side
  - ☐ Back
  - ☐ Stomach
  - ☐ All
- **Activity:**
  - ☐ Sedentary
  - ☐ Active
  - ☐ Very Active
- **Mattress Age:** _____
- **What treatments have you tried to treat your symptoms:**
  - ☐ Chiropractic
  - ☐ Joint Injections
  - ☐ Physical Therapy
  - ☐ Heat
  - ☐ Acupuncture
  - ☐ Medication
  - ☐ Trigger Point Injections
  - ☐ Msssage
  - ☐ Ice
  - ☐ Other: _____

_____

INITIAL TREATMENT GOAL

What would you like to achieve from treatment? _____

_____

What treatments are you interested in trying?

- ☐ Chiropractic
- ☐ Medication
- ☐ Joint Injections
- ☐ Massage Therapy
- ☐ Exosomes
- ☐ Trigger Point Injections
- ☐ Physical Therapy
- ☐ Laser Therapy
- ☐ Dry Needling
- ☐ PRP

- **Type of Adjustments Preferred:**
  - ☐ Diversified (Popping Sound)
  - ☐ Mobilization (Noiseless)
  - ☐ Activator or Instrument Adjustment
  - ☐ Thompson Drop
  - ☐ Other: _____

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

  Last Adjustment: _____

MEDICATIONS

Include All Over-the-Counter and Supplements

MEDICATION NAME	STRENGTH/HOW OFTEN

ALLERGIES

MEDICATION/SUBSTANCE	REACTION

MEDICAL HISTORY

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

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

☐ Others: _____

- **Do you have a demand pacemaker, cardiac defibrillator or implantable stimulator?** ☐ Yes

  Type: _____

- **Past Surgical History: (Procedure / Date / Provider)**

  _____

  _____

  _____

- **Family History:**
  Significant Medical Illnesses

  ☐ Cancer
  ☐ Heart Disease
  ☐ Diabetes
  ☐ Other:_____

- **Have you had any diagnostic studies?**

  ☐ MRI
  ☐ Xray
  ☐ CT Scan
  ☐ NCV
  ☐ Diagnostic Ultrasound

  If yes, please list body part area, date and location:

  _____

  _____

  Other: _____

- **Women:**
  Are you currently pregnant or planning on becoming pregnant?

  ☐ Yes ☐ No

  # of Pregnancies: _____

  # of Deliveries: _____

MEDICAL HISTORY (CONTINUED)

Have you experienced any of the following in the past month? Check all that apply. ☐ None *Skip This Section*

- **Constitutional**
  - ☐ Weakness
  - ☐ Fatigue
  - ☐ Weight Loss/Gain
  - ☐ Chills
  - ☐ Night Sweats
  - ☐ Fevers
- **HEENT**
  - ☐ Headache
  - ☐ 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
- **Allergic/Immune**
  - ☐ Autoimmune Disease
  - ☐ Communicable Disease
- **Neurologic**
  - ☐ Numbness
  - ☐ Tingling
  - ☐ Weakness
  - ☐ Dizziness
  - ☐ Imbalance
  - ☐ Difficult 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
  - ☐ Shoulder Pain
  - ☐ Mid-Back Pain
  - ☐ Knee Pain
- **Endocrine**
  - ☐ Easy Bruising
  - ☐ Easy Bleeding
  - ☐ Swollen Glands
- **Heme/Lymph**
  - ☐ Heat Intolerance
  - ☐ Cold Intolerance
  - ☐ Changes in Appetite
  - ☐ Changes in Thirst

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. of Packs Per Day: _____

  Year Quit: _____

- **Current or history of caffeine use?** ☐ Yes ☐ No

  Drinks Per Day: _____

  Year Quit: _____

- **Current or History of Vape/E-Cigarette use?** ☐ Yes ☐ No

- **Present Living Situation**
  - ☐ Alone
  - ☐ w/ Spouse/Partner
  - ☐ w/ Children
  - ☐ w/ Parents
  - ☐ w/ Others

- **Present Living Situation**
  - ☐ Married
  - ☐ Divorced
  - ☐ Widowed
  - ☐ Single
  - ☐ Partner

- **Occupation**

  _____

- **Employer**

  _____

  ☐ Not Working ☐ Retired ☐ In School ☐ Prefer Not To Say

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:**_____

PROVIDER NOTES

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GENERAL INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Out of State Address: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female ☐ Other ☐ Pefer Not To Say

Height: _____ Weight: _____ Referred By: _____

Appointment Reminders: ☐ Email ☐ Text ☐ Business Card

Emergency Contact: _____

Emergency Contact Phone: _____

Relationship: _____

INSURANCE INFORMATION

Primary Insurance Co: _____

Membership #: _____ Group #: _____

Secondary Insurance Co: _____

Membership #: _____ Group #: _____

AUTO ACCIDENT/WORKERS COMPENSATION ONLY

This section MUST *be filled out for us to bill your insurance & accident info documented.*

Insurance Co: _____ Claim #: _____

Adjustor's Name: _____ Phone Number: _____

Attorney's Name: _____ Phone Number: _____

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: Stephanie Ahasic, DC; Laurie MacKinnon, DC; James Michael Ray, MD; Kevin Smith, DC; Jean Kelly, DC; Lindsay Benezra, PTA; Luke Schaefer, DPT; Joe Peckfelder, PTA; J. Brianne Cummings, ARNP; and licensed massage therapists and medical assistants. 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 rendering provider to be able to anticipate and explain all risks and complications, and I wish to rely on the rendering provider to exercise judgement during the course of the procedure which the rendering provider 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 or 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 relatives 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 Integrated Healthcare, Inc. 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 Integrated Health's Notice of Privacy Practices that describes how my Protected Health Information is used and shared. I understand Synergy Integrated Healthcare, Inc. has the right to change this notice at any time. I may obtain a current copy by contacting Synergy Integrated Healthcare, Inc. 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 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.

Patient Signature: _____ Date:_____

Phone #: _____