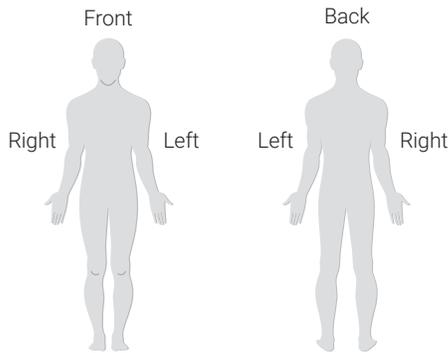


CHIEF COMPLAINT

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
- Standing
- Sleep Position
- Other: _____
- Activity
- Rest

• What makes your symptoms better?

- Sitting
- Standing
- Sleep Position
- Other: _____
- Activity
- Rest

• Sleep Position:

- Side
- Back
- Stomach
- All

• Activity:

- Sedentary
- Active
- Very Active

• What treatments have you tried to treat your symptoms:

- Chiropractic
- Medication
- Joint Injections
- Trigger Point Injections
- Physical Therapy
- Massage
- Heat
- Ice
- Acupuncture
- Other: _____



INITIAL TREATMENT GOAL

What would you like to achieve from treatment? _____

What treatments are you interested in trying?

- | | |
|---|---|
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Trigger Point Injections |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Joint Injections | <input type="checkbox"/> Laser Therapy |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Dry Needling |
| <input type="checkbox"/> Exosomes | <input type="checkbox"/> 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:

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

• Neurologic

- Numbness
- Tingling
- Weakness
- Dizziness
- Imbalance
- Difficult Walking
- Fainting
- Unsteady Gait

• Psychiatric

- Depression
- Anxiety
- Insomnia

• Allergic/Immune

- Autoimmune Disease
- Communicable Disease

• 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

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 Prefer 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 #: _____

