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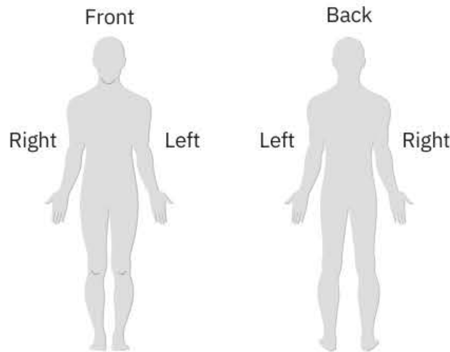
Name: ______________________ Date: ______________________

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**

Other area not listed: ___________________________

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
  - ☐ Massage
  - ☐ 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

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

Last Adjustment:_____________________________

- Type of Adjustments Preferred:

☐ Diversified (Popping Sound)
☐ Mobilization (Noiseless)
☐ Activator or Instrument Adjustment Thompson
☐ Drop Other:
☐ ____________________________________

MEDICATIONS *Include All Over-the-Counter and Supplements*

MEDICATION NAME	STRENGTH/HOW OFTEN

ALLERGIES

MEDICATION/SUBSTANCE	REACTION

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MEDICAL HISTORY

Check a box if you have a **personal** history of the 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
- ☐ Osteoar thritis
- ☐ 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 ☐ No

  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 imaging office:

  ____

  ____

  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

Activity Level

- Typical Activity Level:

☐ Sedentary -less than 30 minutes per day of intentional exercise

☐ Lightly Active -intentional exercise daily for at least 30 minutes per day

☐ Moderate -intentional exercises daily equivalent to brisk walking for at least 90 minutes or vigorous activity of 50 minutes

☐ Very Active - Intensional exercise that is quivalent to 4 hours of brisk walking or shorter periods of very vigorous activity

Sports or activity type: ______________________

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 informa- tion 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: _________________________________

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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 at Synergy Integrated Healthcare Inc, DBA Synergy Health: Stephanie Ahasic, DC; Laurie MacKinnon, DC; Kevin Smith, DC; Avalon Liscio, DC; Brian Spencer, ARNP, Benjamin Mendelsohn, MD; Gregory Riordan, DPT 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, physical therapy, acupuncture and massage therapy, there are some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains, muscle soreness, bruising. 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. Failure to sign this will require payment in full at the time of service.

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 DBA Synergy Health for medical supplies and/or medication(s) furnished to me by Synergy Integrated Healthcare DBA Synergy 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 is resoponsible for any services excluded from their healthcare plan.

Patient Signature: Date:

____

Phone #: Email Address:

____