



PATIENT INFO

Name: _____
(LAST) (MI) (FIRST)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

DOB: ____ / ____ / ____ Soc. Sec #: ____ - ____ - ____

Driver's License #: _____ State: _____

Marital Status: S M W Spouse's Name: _____

Your Employer: _____ Occupation: _____

Employer Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referred By: _____ Primary Care Physician: _____

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name: _____

Member #: _____ Group #: _____

Insurer's Name (If Different From Patient): _____ Relationship to Patient: _____

Insurer's DOB: ____ / ____ / ____ Insurer's Soc. Sec #: ____ - ____ - ____

Insurer's Employer: _____

Person responsible for account: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient/Guardian Signature _____ Date: _____



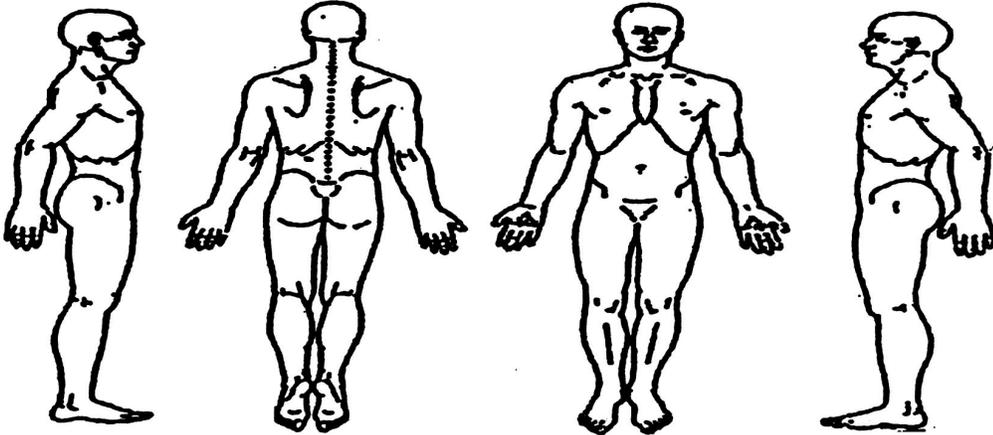
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Today's problem will be filed as: Insurance/ Self Pay Auto Accident Workman's Compensation

2. What is your primary area of concern/ pain? _____

3. Indicate on the drawings below where you have pain/symptoms:



4. How would you describe the type of pain?

- Sharp Numb
 Dull Tingly
 Diffuse Sharp with motion
 Achy Shooting with motion
 Burning Stabbing with motion
 Shooting Electric-like with motion
 Stiff Other: _____

5. How long have you had this problem? _____

6. How do you think your problem began? _____

7. How often do you experience your symptoms?

- Constantly (76-100% of the Time) Occasionally (26-50% of the Time)
 Frequently (51-75% of the Time) Intermittently (1-25% of the Time)

8. On a scale from 0-10 (10 being the worst), how would you rate your pain?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

9. What aggravates your problem? _____

10. What alleviates your problem? _____

11. How are your symptoms changing with time?

- Getting worse Staying the same Getting better



12. What is your: Height _____ Weight _____ Date of Birth _____

Occupation _____

13. How would you rate your overall health?

- Excellent Very Good Good Fair Poor

14. Rate your level of exercise activity:

- Strenuous Moderate Light None

15. Indicate if you suffer from or have immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

16. For the conditions listed below, please check the "past" column if you have had the condition in the past; If you presently have a condition listed below, please check the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		Females Only
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer	<input type="checkbox"/>	<input type="checkbox"/> Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		

17. List all prescription and over-the-counter medications you are currently taking:

18. List all nutritional supplements you are currently taking:



19. List all surgical procedures you have undergone:

20. What activities do you do at work?

- | | | | |
|------------------|---|--|--|
| Sit | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| Stand | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| Computer Work | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| On the Phone | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| Drive | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> A little of the day |
| Other Activities | <input type="checkbox"/> Perform manual labor | <input type="checkbox"/> Read a lot | <input type="checkbox"/> Travel frequently |

21. What activities do you enjoy outside of work?

22. Have you ever been hospitalized? Yes No

If yes, why? _____

23. Have you had past trauma such as car accidents (ever?), falls, sports injuries, etc? Yes No

If yes, what and when? _____

24. Is there anything else you wish to let the doctor know about your visit today? Yes No

If yes, what? _____

Patient Signature _____ **Date** _____



Insurance Verification Disclosure/Agreement

As a courtesy, Synergy Sports Rehab & 1rst Health will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____



Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disk herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.



Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Secondary Number: _____

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Witnessed By _____ Date _____



Assignment of Benefits

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities ("payers"), which may elect or be obligated to pay, provide or distribute proceeds to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to **pay directly and exclusively in the name of 1rst Health** ("office") such sums as may be owed said offices for charges incurred by me at the office relating to my condition ("charges"), with such payment to **be made exclusively in the name of 1rst Health**. For the purposes of this document (herein, "assignment"), "proceeds" shall include, but not be limited to, monies/proceeds from any settlement, judgment, or verdict, as well as any monies/proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter, I direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this assignment. I further authorize and direct all payers to release to office any information regarding any coverage or benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this assignment, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize 1rst Health to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of any account relating to me, my spouse, or any of my dependents.

I understand that I remain personally responsible for the total amounts due 1rst Health for said services. If I discontinue treatment against the medical opinion/advice of my treating doctor, the balance of charges for services rendered will be due and payable immediately. If the office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse **1rst Health** for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

This assignment shall not be modified or revoked without the mutual written consent of 1rst Health and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this assignment.

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____



HIPAA Disclosure

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes:

All Patient Medical Records

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Core Physical Medicine and/or 1rst Health

Expiration Date of Authorization

This authorization is effective through 12/2013 unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I have read the above and hereby authorize Synergy Sports Rehab Office Manager to use my protected information for the listed reasons.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager _____ Date _____



Release of Medical Records

I, _____, hereby authorize the release of my medical records

From:

To:

Synergy Sports Rehab

Mail to:

Fax to:

Print Name

Signature

Social Security Number

Date of Birth

Date