

SYNERGY REHAB & CHIROPRACTIC, LLC
NEW PATIENT INTAKE FORM

DATE: _____

NAME: _____ DOB: ____/____/____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL # _____ WORK# _____

EMAIL: _____ SEX: M F

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE _____ CELL PHONE: _____

MARRIED *DIVORCED* SEPARATED *SINGLE* WIDOWED *MINOR* PARTNERED

OCCUPATION: _____

EMPLOYER/SCHOOL: _____

EMP/SCHOOL ADDRESS: _____

_____ EMP/SCHOOL PHONE: _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE

INSURANCE CO: _____ ID# _____

NAME OF POLICY HOLDER: _____

POLICY HOLDER'S DOB: ____/____/____ RELATIONSHIP TO PT: _____

IS PATIENT COVERED BY ADDITIONAL INSURANCE: YES NO

IF YES: NAME OF INSURANCE CO _____

POLICY #: _____ POLICY HOLDER'S NAME: _____

I certify that I, and/or my dependent(s), have insurance coverage as listed above and assign directly to Synergy Rehab and Chiropractic, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I authorize the use of my signature on all insurance submissions. Synergy may use my health care information and may disclose such information to the above mentioned insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

Signature of patient, parent or guardian

Printed name

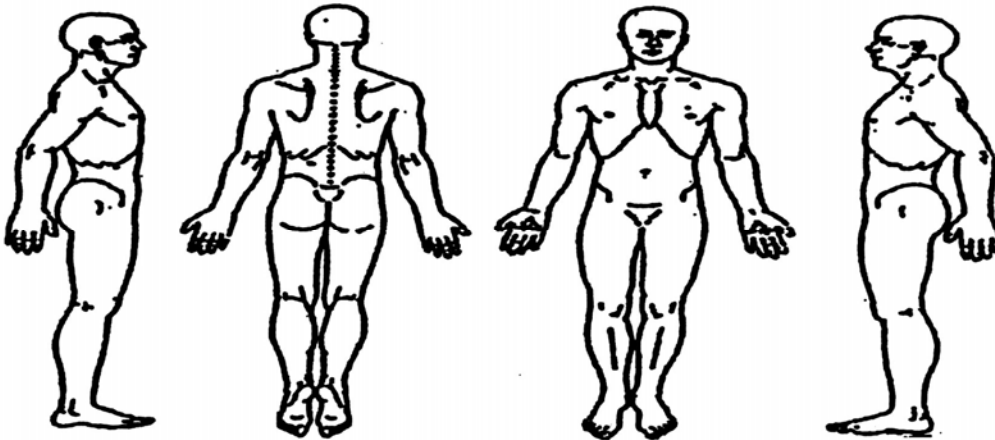
DATE

Patient Name: _____

Date: _____

1. Is today's problem caused by: Auto Accident Workman's Compensation

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



3. 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)

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 are your symptoms changing with time?

- Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

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

7. How much has the problem interfered with your work?

- Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

- Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician
 ER physician Orthopedist Other: _____
 Massage Therapist Physical Therapist No one

10. How long have you had this problem? _____

11. How do you think your problem began?

12. Do you consider this problem to be severe?

- Yes Yes, at times No

13. What aggravates your problem?

14. What concerns you the most about your problem; what does it prevent you from doing?

15. What is your: Height _____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?

- Excellent Very Good Good Fair Poor

17. What type of exercise do you do?

- Strenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

- Rheumatoid Arthritis Diabetes Lupus
 Heart Problems Cancer ALS

