

WELCOME



SYNERGY RELEASE SPORTS
The Pro's Choice for Sports Rehabilitation and Prevention

ABOUT YOU

Today's Date: _____ / _____ / _____ File #: _____

Patient's Name: _____ Preferred Name: _____

Last First MI

Male Female Status: Single Married Divorced Separated Widowed

Birthdate: _____ / _____ / _____ Age: _____ SSN: _____

Mailing Address: _____ Home Phone: _____

Work Phone: _____

City State Zip Cell Phone: _____

* E-Mail: _____

Referred by: _____

Employer: _____ Occupation: _____

Spouse's Name: _____

Do you have children? Yes No

How Many? _____

SPORTS

Affiliation: (ex. Alta Tennis) _____

Interest: Golf, Tennis, Football, Soccer, Cheerleading

Running, Weight Training, Baseball, _____

Type of Injury: _____

Child 1: Age _____ Gender _____ Sports _____

Child 2: Age _____ Gender _____ Sports _____

Child 3: Age _____ Gender _____ Sports _____

INSURANCE INFORMATION

Co. Name

Address:

City State Zip

Phone #:

ID #: Group #:

Insured's Name:

Relation: DOB:

Insured's Employer:

REASON FOR VISIT

The reason for this visit is a result of (Please Circle): work, sports, auto, trauma or chronic

(Explain what happened): _____

Please describe the pain & its location: _____

When did the condition begin? _____ / _____ / _____

Is this condition getting worse? Yes No Constant Comes and Goes

Is this condition interfering with your (Please Circle): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? Yes No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No

If so, where? _____

Have you ever been treated by a Chiropractor before? Yes No

If so, whom? _____ Phone #: _____

IN THE EVENT OF AN EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work #: _____

Who is your Medical Doctor? _____

Phone #: _____



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HEALTH HISTORY

Are you taking any of the following medications?

- Nerve pills Pain Killers (including aspirin) Muscle Relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other (s)

Do you have or ever had any of the following diseases or conditions?

- | | | | | | |
|-----|----------------------------|-----|--------------------------|-----|-------------------|
| Y N | Heart Attack/Stroke | Y N | Heart Surg./Pacemaker | Y N | Heart Murmur |
| Y N | Congenital Heart Defect | Y N | Mitral Valve Prolapse | Y N | Artificial Valves |
| Y N | Alcohol/Drug Abuse | Y N | Venereal Disease | Y N | Hepatitis |
| Y N | HIV +/-Aids | Y N | Shingles | Y N | Cancer |
| Y N | Frequent Neck Pain | Y N | Emphysema/Glaucoma | Y N | Anemia |
| Y N | High/Low Blood Pressure | Y N | Psychiatric Problems | Y N | Rheumatic Fever |
| Y N | Severe/ Frequent Headache | Y N | Kidney Problems | Y N | Ulcer/Colitis |
| Y N | Fainting/Seizures/Epilepsy | Y N | Sinus Problems | Y N | Asthma |
| Y N | Diabetes/Tuberculosis | Y N | Difficulty Breathing | Y N | Chemotherapy |
| Y N | Lower Back Problems | Y N | Artificial Bones/ Joints | Y N | Arthritis |

Please list any other serious medical condition(s) you have or ever had:

Please list anything that you may be allergic to:

List previous surgeries/treatments with dates:

List any past serious accidents with dates:

Family Health History:

- Do you: Take Supplements or Vitamins? Yes No / Exercise? Yes No
- Are you on a special diet: Yes No/ Since: _____/_____/_____
- Do you smoke? No Yes How much? _____ How long? _____
- Are you wearing? Heel Lifts Sole Lifts Inner Soles Arch Supports
- What is the age of your mattress? _____ Is it comfortable? Yes No
- For Women: Are you taking Birth Control? Yes No
- Are you Pregnant? No Yes / How long? _____ Nursing? Yes No

ACCOUNT INFO

Person ultimately responsible for account

Name: _____ Relation: _____

Billing Address: _____ SSN: _____ DOB: _____

Payment method: Cash Check _____ Credit Card #

_____ I hereby authorize assignment of directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered by this office).

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date: _____/_____/_____



PAIN CHART

ABOUT YOU

Name: _____ File # _____

What is your current weight: _____ lbs. and height _____ Ft _____ In.

Please describe your condition: _____

Signature: _____ Date: ____ / ____ / ____

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description >>>
Symbol >>>

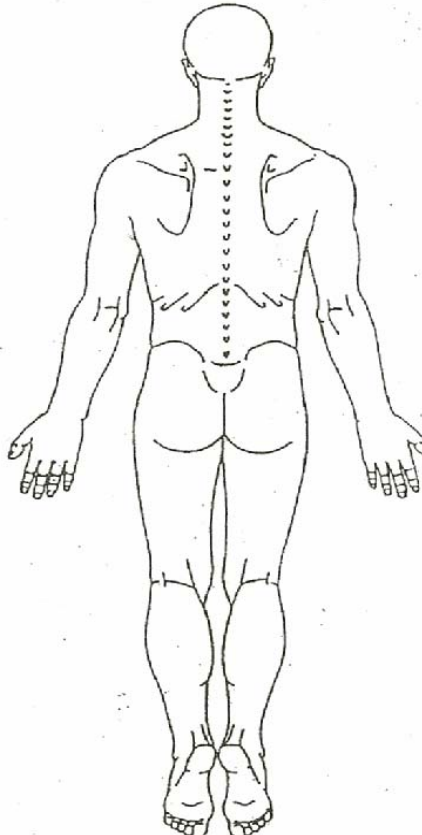
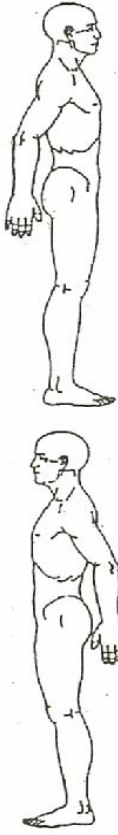
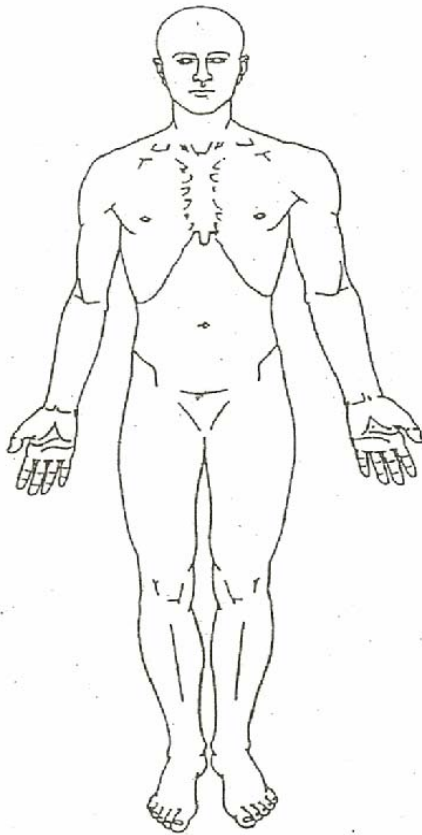
Numbness
NNNN

Pins & Needles
PPPP

Burning
BBBB

Aching
AAAA

Stabbing
SSSS



DOCTOR'S NOTES
