WELCOME to Synergy Sports Wellness & Performance

About You

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

Patient's Name:_____ Preferred Name:_____
Last First MI

☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Birthdate: _____/_____/_____ Age:_____

Mailing Address:_____ Home Phone: _____

_____ Work Phone: _____

City State Zip Cell Phone: _____

* **E-Mail:** _____

Referred by: _____ I want to receive news and updates ☐ Yes ☐ No

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_____

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 #:_____

Synergy Sports Wellness & Performance

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?

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Attack/Stroke	☐	☐	Heart Surg./Pacemaker	☐	☐	Heart Murmur
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse	☐	☐	Artificial Valves
☐	☐	Alcohol/Drug Abuse	☐	☐	Venereal Disease	☐	☐	Hepatitis
☐	☐	HIV +/Aids	☐	☐	Shingles	☐	☐	Cancer
☐	☐	Frequent Neck Pain	☐	☐	Emphysema/Glaucoma	☐	☐	Anemia
☐	☐	High/Low Blood Pressure	☐	☐	Psyciatric Problems	☐	☐	Rheumatic Fever
☐	☐	Severe/ Frequent Headaches	☐	☐	Kidney Problems	☐	☐	Ulcer/Colitis
☐	☐	Fainting/Seizures/Epilepsy	☐	☐	Sinus Problems	☐	☐	Asthma
☐	☐	Diabetes/Tuberculosis	☐	☐	Difficulty Breathing	☐	☐	Chemotherapy
☐	☐	Lower Back Problems	☐	☐	Artificial Bones/ Joints	☐	☐	Arthiritis

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:

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 Information

Person ultimately responsible for account

Name:_____ Relation:_____

Billing Address:_____ DOB:_____

__ 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 arrangemnts 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: _____/_____/_____

Life Style

Do you take Supplements or Vitamins? ☐ Yes ☐ No

If so what kind: ☐ Multi ☐ Energy ☐ Anti Inflammatory ☐ Joint Care

☐ Immune Building ☐ Bone Care Other_____

Do you exercise regularly? ☐ Yes ☐ No If so what type of exercise? _____

Do you have allergies? ☐ Yes ☐ No If so for how many years? _____

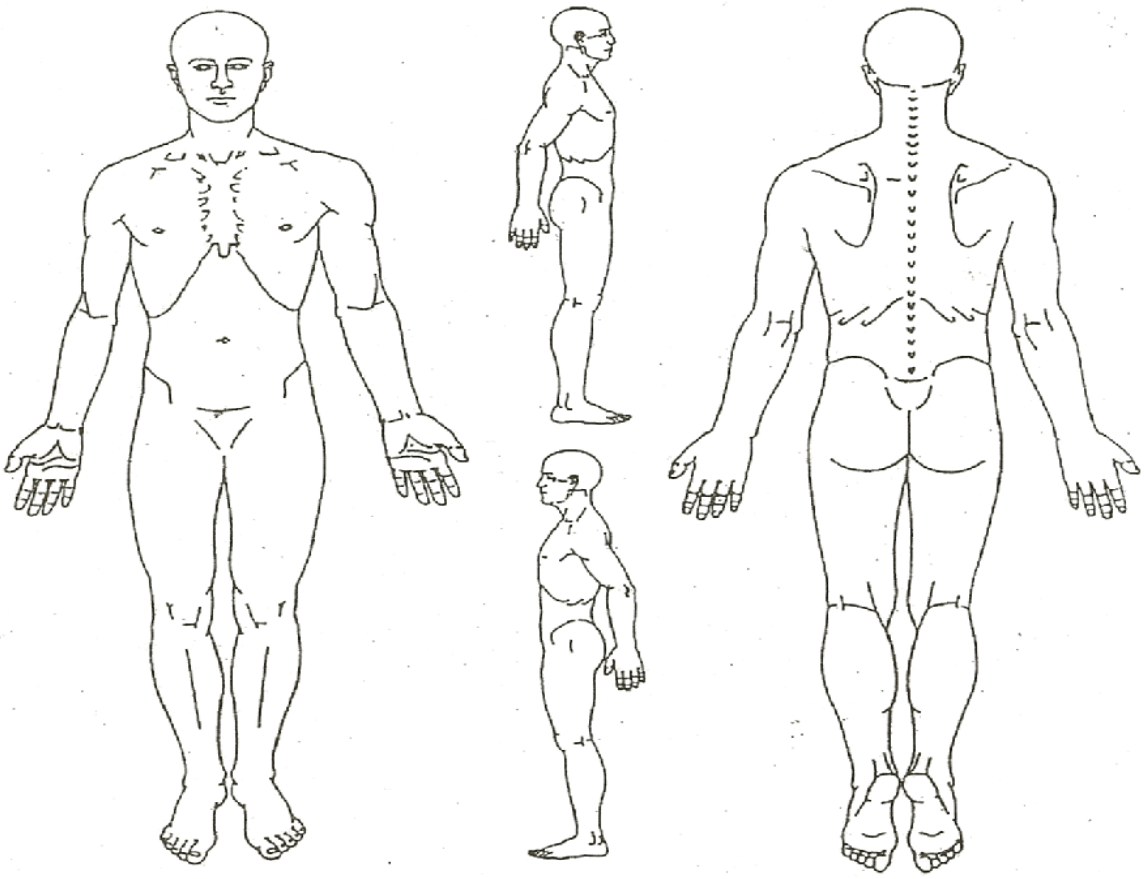
Are you interested in weight loss? ☐ Yes ☐ No

Current Height _____ft_____in **Current Weight _____lbs**

Pain Chart — 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 ➤➤➤	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol ➤➤➤	NNNN	PPPP	BBBB	AAAA	SSSS



Synergy Sports Wellness & Performance

Dr. Roberts

PATIENT CONSENT & AUTHORIZATION

ALL Patients Initial at 1,2,3,4 -- IF appropriate Initial at 5,6, or 7

1._____Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

2._____Release of Information: By my signature on this form, I am granting consent to the Providers at Synergy Sports Wellness & Performance to use and disclose protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

Our Notice of Privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant you request; however, if we do decide to grant your request, we are bound to disclose your protected health information in reliance on your request. I acknowledge that I have received a copy of the Notice of Health Information Privacy Practices.

3._____Assignment of Benefits: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physicians' regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

4._____Resolution of Disputes: In the rare circumstance that a dispute arises regarding any matter connected with this office, I agree that independent arbitration will be entered into and completed before any legal action can be taken. I further understand that if I am not satisfied with the results of the arbitration, I am free to pursue any other legal remedy at that time.

5._____Medicare and Medicaid Consent to Release Information: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare or Medicaid claim.

6._____ (Female Patients ONLY) Verification of Non-Pregnancy: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed, at this particular time.

The date of last menstrual period _____(start/end).

7._____Permission to Evaluate and Treat a Minor Child/ Dependant Adult: I authorize the office to evaluate and treat _____.

Print Patient's Name: _____

Patient's Signature: _____Date:_____

Parent/Guardian Permission to treat: _____

Relationship: _____ Date:_____

Witness: _____ Date:_____

Patient has received a copy of the Notice of Privacy Practices.