

1. PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name _____

Address _____
First Name _____ Middle Initial _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for ____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone () _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Who may we thank for referring you? _____

3. PHONE NUMBERS

Cell PH () _____ Home PH () _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home PH () _____ Work PH () _____

2. INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

Policy # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____ Group # _____

Policy # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents(s) have insurance coverage with _____ and assign directly to _____ Synergy Institute 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 by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent

Date Relationship to Patient

4. ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5. PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

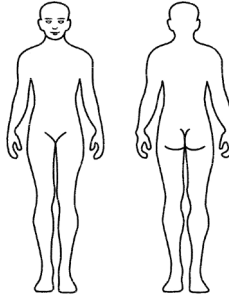
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



6. HEALTH HISTORY

What treatment have you already received for your condition? Medication Surgery Physical Therapy Acupuncture Massage
 Chiropractic services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following: _____

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexually Transmitted		
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriages	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____		
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

7. EXERCISE

- None
- Moderate
- Daily
- Heavy

8. WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

9. HABITS

- Smoking _____ Packs/Day _____
- Alcohol _____ Drinks/Week _____
- Coffee/Caffeine Drinks _____ Cups/Day _____
- High Stress Level _____ Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Car Accidents	_____	_____

10. MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
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Sign up for our FREE Newsletter and get entered to win a 5 Massage package worth \$295.00!

I, the undersigned, am providing Synergy Institute with my email address. I understand that by providing my email address to Synergy Institute you have my permission to communicate with me via email. I also understand that Synergy Institute will not share or provide my street address, phone, fax, nor email address in any way, for any reason, to any third party. I also understand that I can request to have my street and email address removed from Synergy Institute's list any time. I also understand that by providing my email address, I will receive a FREE subscription to Synergy Institute's Newsletter ... and automatically entered into a drawing for a \$295 massage as explained above. On this basis, my current email address is provided below:

Email _____ Signature _____ Date _____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME _____ DATE _____

For any YES answer, please notify the Doctor:

- | | | |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms, or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness, or burning in your shoulder, arms, or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling or swelling in your hands and arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness, or burning in your buttocks, legs, or feet?
Comment: _____ | NO | YES |
| 8. Do your legs or feet regularly fall asleep?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling or swelling in your legs and/or feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Do you suffer from headaches, dizziness, or memory loss?
Comment: _____ | NO | YES |
| 12. Do you have difficulty maintaining your balance?
Comment: _____ | NO | YES |
| 13. Do you suffer from vertigo or blurred vision?
Comment: _____ | NO | YES |
| 14. Do you suffer from reduced hearing capacity?
Comment: _____ | NO | YES |
| 15. Do you suffer from ringing in your ears?
Comment: _____ | NO | YES |
| 16. Do you have bladder or bowel control problems on a regular basis?
Comment: _____ | NO | YES |

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

I hereby acknowledge receipt of the Notice of Privacy Practice for **Synergy Institute** regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by the **Synergy Institute** and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting **Synergy Institute**.

Naperville: (630-355-8022 at 2011 South Washington St, Naperville IL 60565).

Aurora: (630-236-4876 at 1669 Montgomery Rd Unit 8, Aurora IL 60504).

My signature herein below constitutes full acknowledgement that I have been furnished a copy of the Notice of Privacy Practices for **Synergy Institute**.

Patient Signature

Date

Patient's Legal Representative (if required)

Date

If signed by patient's legal representative, please state representative's relationship to the patient:

_____.

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

Patient Signature

Date

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

No. I am definitely not pregnant at this time.

Yes. I am definitely pregnant.

There is a possibility that I may be pregnant at this time.

Patient Signature

Date