



Synergy Medical
 16705 Square Drive
 Marysville, Ohio 43040

Pediatric Intake

Patient Name _____ **DOB:** _____ Male Female

SS#/ SIN _____

Email _____ Home Phone _____ Cell Phone _____

Patient's Address _____ City _____ State _____ Zip _____

Parent/Guardian Name _____ Parent/Guardian's Employer _____

How did you hear about us? _____

Emergency Contact _____ Phone _____

Responsible Party

Name of the person responsible for this account _____ Relationship to patient _____

Is the person currently a patient at our office? Yes (skip rest of this section) No

Email _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Driver's License # _____ Date of Birth _____

Do you have Medical Insurance? Yes No if yes, complete the following:

Name of the insured _____ Relationship to patient _____

Birthdate _____ SS#/SIN _____ Work Phone _____

Name of Employer _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ ID # _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

 Parent or Guardian _____ Date

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
 AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
 AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Buckeye Chiropractic and Wellness/Synergy Medical, Doctor Charita Cooper, Doctor Patrick Cooper, and Jennifer Roby CNP** as well as all employees, employers, representatives, and agents thereof (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with the same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that the Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20____. X _____

(Patient signature)

X _____

(Signature of Guardian if applicable)

X _____

(Please print patient name)

Present Health Concerns

Major: _____

Minor: _____

When did this problem begin? _____

Is this problem: Occasional Frequent Constant Intermittent

Does this problem radiate? Yes No If Yes, where? _____

What makes this worse? _____

What makes this better? _____

Is the problem worse during a certain time of the day? Yes No If Yes, when? _____

Does this interfere with the child's sleep? Yes No Eating? Yes No

Is this becoming worse? Yes No Daily routine? Yes No

Often seemingly unrelated symptoms can manifest as other health concerns.. Please check if your child has had any of the following:

- Headaches
- Dizziness
- Frequent colds
- Sinus congestion
- Heart palpitations
- Numbness in feet
- Numbness in hand(s)
- Weakness
- Heartburn
- Muscle cramps
- Upper back pain
- Neck pain
- Loss of taste
- Light sensitivity
- Face flushed
- Reduced mobility
- Other: _____
- Chest pressure
- Breast pain
- Dental problems
- Fevers depression
- Loss of balance
- Loss of concentration
- Fainting
- Ears buzzing
- Poor coordination
- Vision changes
- Loss of memory
- Loss of smell
- Constipation
- Diarrhea
- Urinary problems
- Bloating/gas
- Weight loss
- Weight gain irritability
- Fatigue
- Sore throats
- Ear pain/infections
- Asthma
- Cold sweats
- Bronchitis
- Pneumonia
- Difficulty breathing
- Shortness of breath
- Low back pain
- Radiating pain
- Sleeping problems
- Numbness in leg(s)
- Stiffness

Drug Allergies:

Birth History

What was the child's gestational age at birth? _____ Weeks

Birth weight: _____ lbs _____ oz Birth length: _____ inches

Was your child's birth: At home In a birthing center Hospital Other

Was the birth considered: Medical Midwife Duration of birth: _____ hours

Was child born: Cephalic (head first) Breech (feet first)

Were there any complications? Yes No If Yes, please explain _____

Assistances used during delivery: Forceps Vacuum extraction C-section Episiotomy

Was labour: Spontaneous Induced

Were medications or epidurals given to the mother during birth? Yes No

APGAR score: At Birth____/10 After 5 minutes____/10

Is there anything else we need to know about this birth? Yes No

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? Yes No

If no, please explain_____

At what age did the child:	Respond to sound:_____	Follow an object:_____
	Hold up head:_____	Vocalize:_____
	Sit alone:_____	Teethe:_____
	Crawl:_____	Walk:_____

Does your child sleep: Front Back Side

Do you consider the child's sleeping pattern normal? Yes No How many hours per day?_____

If no, please explain_____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family:_____

Fathers family:_____

Siblings:_____

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any trauma to the mother during pregnancy? (ie, falls, accidents, etc.) Yes No

If yes, please explain_____

Any evidence of birth trauma to the infant?

Bruising Odd shaped head Stuck in birth canal Fast or excessively long birth

Respiratory depression Cord around neck

Any falls from couches, beds, change tables, etc? Yes No

If yes, please explain_____

Any traumas resulting in bruises, cuts, stitches or fractures? Yes No

If yes, please explain_____

Any hospitalizations or surgeries? Yes No

If yes, please explain_____

Any sports played?_____ Is a school

backpack used? Yes No Is it heavy or light?_____

Chemical Stressors

Was this child breast-fed? Yes No If yes, how long? _____ Formula introduced at what age: _____

Which formula? _____

Introduction of cow's milk at what age: _____

Began solid foods at what age: _____

Types of solid foods: _____

Food/Juice intolerance? Yes No Type: _____

Is your child on or have taken any medications? Yes No

If yes, when and what type: _____

During the mother's pregnancy:

Did the mother smoke? Yes No If yes, How much? _____

Drink alcohol? Yes No If yes, How much? _____

Any illnesses during the pregnancy? Yes No

If yes, please describe _____

Any supplements taken during pregnancy? Yes No

If yes, please describe _____

Any drugs taken during pregnancy? Yes No

If yes, please describe _____

Any ultrasounds? Yes No If yes, How many? _____

Reasons for being done: _____

Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)?

Yes No If yes, please explain _____

Any pets at home? Yes No

Any smokers in the home? Yes No

Any antibiotics given? Yes No If yes, reason: _____

Is the diet organic? Yes No

Do you use 'green products' in your home for cleaning? Yes No

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?

Never On weekends A few times per week Daily Nearly each meal On special occasions

Are you aware of the impact of nutrition on children's behavior? Yes No

Would you like information on nutrition for your child? Yes No

Psychosocial Stressors

Any difficulties with lactation? Yes No If yes, please explain: _____

Any problems with bonding? Yes No If yes, please explain: _____

Any behavioral problems? Yes No If yes, please explain: _____

Any inattention? Yes No If yes, please explain: _____

Any hyperactivity or restlessness? Yes No If yes, please explain: _____

Any compulsiveness? Yes No If yes, please explain: _____

Any difficulties at daycare or school? Yes No If yes, please explain: _____

Any challenges with learning deficiencies? Yes No If yes, please explain: _____

Any night terrors, sleep walking, difficulty sleeping? Yes No

If yes, please explain: _____

Any prolonged temper tantrums or separation anxiety? Yes No

If yes, please explain: _____

Is the child in daycare? Yes No Age of child when began daycare? _____

Is there a nanny or regular sitter during the day if both parents work? Yes No

Is the child home schooled? Yes No By whom? _____

Average number of hours of television per week? _____

Average number of hours of video games per week? _____

Does your child have a cell phone? Yes No

How often do they text or use the phone? _____

Do you feel that your child's social and emotional development is normal for their age? Yes No

If no, please explain: _____

**SYNERGY MEDICAL
CONSENT TO TREAT**

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X Rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Female Only

_____ I am NOT pregnant.

_____ I am pregnant.

Buckeye Chiropractic & Wellness/Synergy Medical

16705 Square Dr. Marysville, OH 43040

(937)642-4400 (p) ~ (937)642-4443 (f)

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individuals and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need the record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our

monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email, or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Patient/Guardian Signature: _____ Date: _____



Jennifer Robyl, CNP

Charita N.Cooper, DC CACCP

Patrick S. Cooper, DC CCEP

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my primary care physician of my condition, treatment and expected/actual response to care at this office.

Patient/Guardian Signature: _____

Name (Please Print): _____

Primary Care Physician: _____

Physician's Address/Phone: _____
