WELCOME TO SYNERGY RELEASE SPORTS

ABOUT YOU

Today's Date:_________/________/___________ **E-Mail:** ____________________________________

Patient's Name:____ Preferred Name:_________________
Last First MI

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

Birthdate: _______/______/________ Age:_________SSN:_______________________

Mailing Address:____ Home Phone:____________________

____ Cell Phone: ____________________

City State Zip Work Phone ____________________

How did you hear about us: Please Circle

Referral / Website / Google / Yelp / Facebook / Instagram / Other _____________

Referred by: ___________________________________

Employer:______________________________ Occupation:___________________________________

Spouse's Name: ___________________________________

Do you have children? ☐ Yes ☐ No How Many? _________

INSURANCE INFORMATION

Insurance Company: ____

Billing Address: ____

____

Phone # for Provider to call: ____

ID #: ____ Group # ____

Insured's Name: _____________________________________ Insured's Employer: __________________________

Relation: ____

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 RELEASE SPORTS

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	Psyciatric Problems	Y	N	Rheumatic Fever
Y	N	Severe/ Frequent Headaches	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:

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:________

_________ 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: _________/__________/__________

LIFESTYLE

Do you take Supplements or Vitamins? ☐Yes ☐No

If so what kind: (please circle) 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

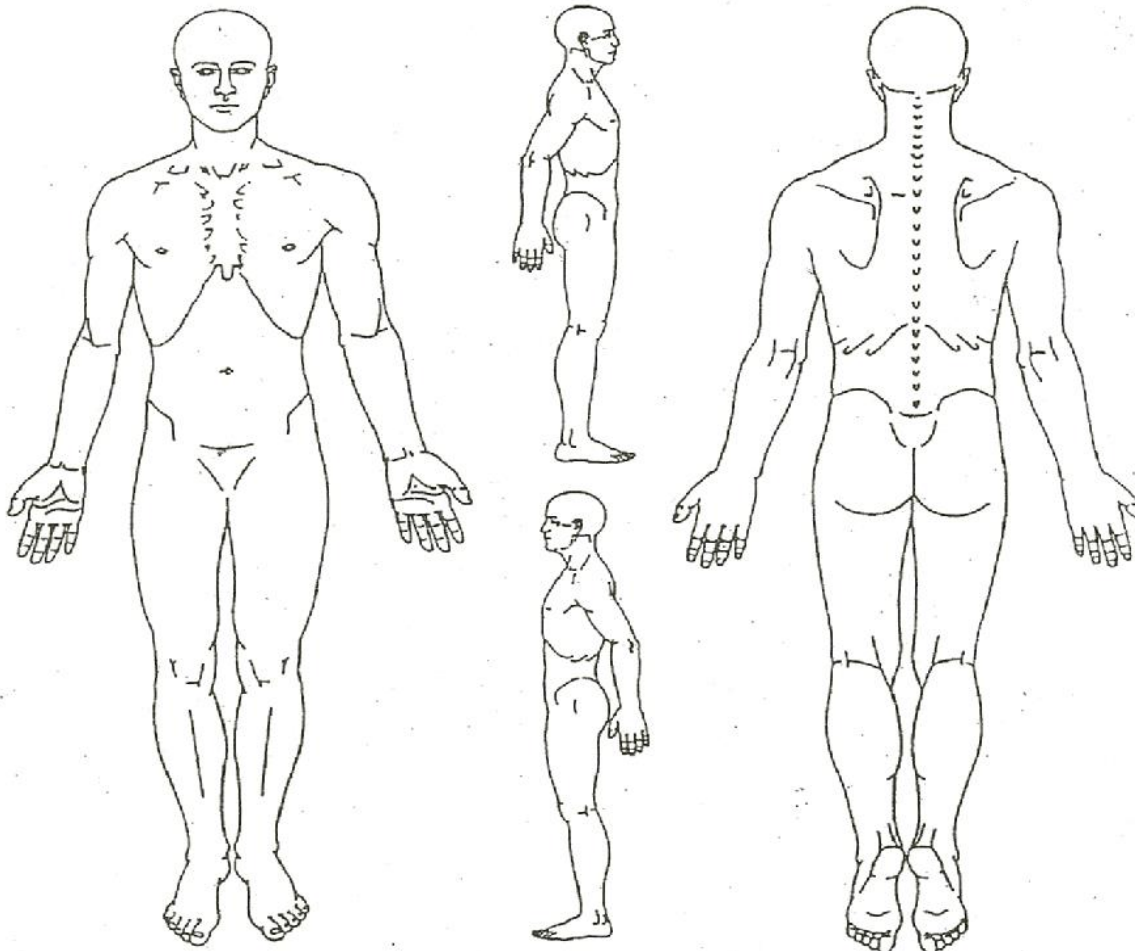
Current Height _______**ft**________**in** **Current Weight** _____________________**lbs**

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



ATHLETE INTAKE FORM

Patient's Name ____

SPORTS

Affiliation: (ex. Alta Tennis)____

Circle all that apply:

Golf Tennis Football Soccer Cheerleading Running Swimming Biking Weight-Training MMA Baseball Lacrosse
Other ____

Type of Injury: ____

Have you ever taken the Impact test (for concussion)? ______________ If yes, when? ____________________________________

If you answered "Yes" to the above, please answer the following:

When was the concussion(s)? ____

Were you diagnosed? ____

How long did your symptoms last? ____

Have you been diagnosed or noticed yourself to have food allergies or sensitivities to food items?

____

If "Yes", who diagnosed you and what foods are you allergic or sensitive to? ____

____

____

____