

# CONFIDENTIAL PATIENT HISTORY

Today's Date  /  /  Signature of Patient \_\_\_\_\_

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Home email \_\_\_\_\_ Work Email \_\_\_\_\_

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

Which email address would you like us to use to communicate with you? (check one)  Home  Work

Contact Method (check one)

Primary Phone  Secondary Phone  Mobile Phone  Home Email  Work Email

Date of Birth  /  /  Age \_\_\_\_\_ Gender (check one)  Male  Female  Unspecified

Marital Status (check one)  Single  Married  Other SSN \_\_\_\_\_

Employment Status (check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

Race (check one)

White  Black/African American  Hispanic  American Indian/Alaskan Native  
 Asian  Asian Indian  Chinese  Filipino  
 Japanese  Korean  Vietnamese  Native Hawaiian or other Pacific Island  
 Samoan  Guamanian or Chamorro  Other \_\_\_\_\_  I choose not to specify

Multi-Racial (check one)  Yes  No  Unknown

Ethnicity (check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (check one)

English  Spanish  American Sign Language  Chinese  French  German  
 Tagalog  Vietnamese  Italian  Korean  Russian  Polish  
 Arabic  Portuguese  Japanese  French Creole  Greek  Hindi  
 Persian  Urdu  Gujarati  Armenian  I choose not to specify

Verification Question (choose only one question by circling the question, then give the answer to that question)

What is the name of your favorite pet?  In what city were you born?  What high school did you attend?  
 What is your favorite movie?  When is your anniversary?  On what street did you grow up?  
 What was the make of your first car?  What is your mother's maiden name?

Verification Answer to the Chosen question: \_\_\_\_\_

*Answers must be at least 6 characters.*

Patient Name: \_\_\_\_\_

Do you currently smoke tobacco of any kind?  Yes  Former smoker  Never been a smoker

If yes, how often do you smoke:  Current every day smoker  Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

0  1  2  3  4  5  6  7  8  9  10  
No interest Very Interested

Current medications, including frequency and dosage if known. If there are no current medications, check here:

|          | Start Date |          | Start Date |
|----------|------------|----------|------------|
| 1) _____ |            | 5) _____ |            |
| 2) _____ |            | 6) _____ |            |
| 3) _____ |            | 7) _____ |            |
| 4) _____ |            | 8) _____ |            |

List any known allergies you have had to any medications. If no allergies are known, check here:

- 1) \_\_\_\_\_ 3) \_\_\_\_\_  
 2) \_\_\_\_\_ 4) \_\_\_\_\_

Briefly list your main health problems: \_\_\_\_\_

Has any doctor diagnosed you with Hypertension presently?  Yes  No If yes, describe: \_\_\_\_\_

Has any doctor diagnosed you with Diabetes presently?  Yes  No If yes, what kind?  Type I  Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?  Yes  No  Not Sure

If yes, other comments regarding Diabetes: \_\_\_\_\_

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?  Yes  No

Medical Physician's name: \_\_\_\_\_

Family Health History (some health problems are the result of familial tendencies)

| Family Member | Illness | Age (or) Age Died | Cause of Death |
|---------------|---------|-------------------|----------------|
| Father        | _____   | _____             | _____          |
| Mother        | _____   | _____             | _____          |
| Brother(s)    | _____   | _____             | _____          |
| Brother(s)    | _____   | _____             | _____          |
| Sister(s)     | _____   | _____             | _____          |
| Sister(s)     | _____   | _____             | _____          |

**Personal Health History** (circle "C" if your problem is current and "P" if you've had the problem in the past):

**General**

- C P Allergy
- C P Convulsions
- C P Fatigue
- C P Fainting
  
- C P Headache
- C P Sudden Weight Loss
- C P High Blood Pressure

**Muscle & Joint**

- C P Arthritis
- C P Bursitis
- C P Low Back Pain
- C P Neck Pain or Stiffness
- C P Shoulder Pain
- C P Spinal Curvature
- C P Mid-back Pain

**Eyes, Ears, Nose & Throat**

- C P Hearing Loss
- C P Ear-ache
- C P Failing Vision
- C P Nosebleeds
  
- C P Sinus Infections
- C P Strep Throat
- C P Thyroid Problems

**Gastrointestinal**

- C P Colon Problems
- C P Constipation
- C P Diarrhea
- C P Gall Bladder
  
- C P Hemorrhoids
- C P Hernia
- C P Liver Problems

**Vascular**

- C P Nausea/Vomiting
- C P Dizziness
- C P Numbness on one side of the face or body
- C P Difficult Swallowing
- C P Difficulty Walking
- C P Difficulty Speaking
- C P Fainting/Light Headed
- C P Double Vision
- C P Rapid Eye Movement
- C P Neck or Head Pain Like Never Before

**Pain or Numbness**

- C P Shoulders/Arms
- C P Elbows/Hands
- C P Hips/Legs
- C P Ankles/Knees/Feet

**Genito-Urinary**

- C P Bedwetting
- C P Frequent Urination
- C P Kidney Infection
- C P Painful Urination
- C P Prostrate Trouble
- C P Kidney Stones

**Skin Problems**

- C P Bruise Easily
- C P Skin Rash
- C P Hives or Allergic Reaction
- C P Acne

**For Women Only**

- C P Cramps/ Backache w/cycle
- C P Excessive Menstrual Flow
- C P Irregular Cycles
- C P Lumps in Breast
- C P Pain w/intercourse
- C P Pelvic Inflammatory Dis.

**Respiratory**

- C P Asthma
- C P Chest Pain
- C P Chronic Cough
- C P Spitting Up Blood

**Other**

- C P Stroke
- C P Rheumatoid Fever
- C P Alcoholism
- C P Diabetes
- C P Cancer
- C P HIV/AIDS

**In the event of an emergency, who should we contact?**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Home/Cell Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

**Insurance Information:**

Company Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of insured: \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Insured ID (if different than SS#) \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Policy/Group # \_\_\_\_\_ Plan Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_ Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**To be performed by clinic staff:**

Height: \_\_\_\_\_ inches    Weight: \_\_\_\_\_ pounds    BP: \_\_\_\_\_ / \_\_\_\_\_

**Synergy Chiropractic and Wellness Solutions, LLC**  
**dba New Smyrna Spine & Injury Center**  
**130 Wallace Road, New Smyrna Beach, FL 32168 – (386) 423-2415**

**Patient Health Information Consent Form**

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be examined one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a compliance officer has been designated to enforce these procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have a right to file a formal complaint with our compliance officer about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctors have the right to refuse to give care.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_

**Informed Consent for Chiropractic Spinal Manipulation, Diagnostic X-Rays and Treatment, Authorization and Release**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities (including but not limited to ultrasound, interferential muscle stimulation, ice, heat, traction, spinal decompression) and diagnostic x-rays on myself or on the patient named below for whom I am legally responsible, by or under the orders of the licensed doctors of chiropractic of Synergy Chiropractic and Wellness Solutions, LLC (dba New Smyrna Spine & Injury Center) or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks

Continued...

Patient Name: \_\_\_\_\_

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and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of my insurance benefits directly to Synergy Chiropractic and Wellness Solutions, LLC (dba New Smyrna Spine & Injury Center). I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize Synergy Chiropractic and Wellness Solutions, LLC (dba New Smyrna Spine & Injury Center) to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand that the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all 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 future condition(s) for which I seek treatment in this office.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_

**Consent to Treatment of a Minor Child:**

I hereby authorize the doctors of Synergy Chiropractic and Wellness Solutions, LLC (dba New Smyrna Spine & Injury Center), and/or whoever they may designate as assistants to administer treatment as deemed necessary to

Name of Minor: \_\_\_\_\_

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Parent or Legal Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_

