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.

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 <u>low back</u> 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…

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: _____/_____/_____

Records Release Authorization

Patient Name: _____

Date of Birth: _____ Social Security No:_____

I authorize the use and disclosure of the above-named individual's health information described below. *Please check only one.*

- ☐ Synergy Chiropractic and Wellness Solutions, LLC, dba New Smyrna Spine & Injury Center is authorized to release the above-named individual's health information to the following individual(s). **A copy fee may be charged. Please see attached policy.**

- ☑ The following individual(s) or organization(s) are authorized to make the disclosure to Synergy Chiropractic and Wellness Solutions, LLC, dba New Smyrna Spine & Injury Center, Don Walsh III, D.C.

Name: _____ Address:_____

Name: _____ Address:_____

Name: _____ Address:_____

The type of information to be used or disclosed (requested) is as follows below and is for the dates from _____ to _____.

- ☐ Copy of history, physical, operative reports and discharge summary
- ☐ Copy of outpatient and ER admissions
- ☐ Copy of complete hospital chart
- ☑ X-Rays, MRI's & all other imaging reports

State and Federal law protect the following information. If any of this information applies to you, please indicate any or all information you would like released.

☑ No substance, psychiatric or HIV treatment records ☐ Alcohol or drug abuse treatment records ☐ Psychiatric treatment ☐ HIV treatment

The information for which I am requesting disclosure will be used for the following purpose:

- ☐ My personal use
- ☑ Physician evaluation and treatment
- ☐ At the request of my attorney: Name: _____
- ☐ Other (please describe): _____

I understand that I have the following rights:

- **Right not to sign**. You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Synergy Chiropractic and Wellness Solutions, LLC except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
- **Right to revoke.** You may revoke this authorization at any time. Your revocation will not apply to any release we have already made in response to this authorization. To revoke this authorization, you must submit a written revocation to our privacy office at the following address: Synergy Chiropractic and Wellness Solutions, LLC, Attention: Privacy Officer, 130 Wallace Road, New Smyrna Beach, FL 32168

Re-disclosure. I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

Expiration date or event: _____. Without expiration date, this release will automatically expire 1 year from date of signature.

I have read and understand this authorization, and authorize the use and/or disclosure of the health information as described in this authorization. A copy of this Authorization or my signature may be used with the same effectiveness as an original.

_____ _____

Signature of patient (or personal representative) Date

_____ _____

Name of personal representative Relationship to patient

New Smyrna Spine & Injury Center – Motor Vehicle Crash Form - Florida

Patient Information

Patient Name: _____ Today's date: _____

Date of injury: _____ Time of injury: _____ ☐ AM ☐ PM

City and Street where crash occurred: _____

What is the estimated damage to your vehicle? $_____

Accident Description

Describe how the crash happened: _____

_____

_____

_____

_____

_____

_____

Collision Description

Check all that apply to you:

☐ Single-car crash
☐ Rear-end crash
☐ Head-on crash
☐ Two-vehicle crash
☐ Side crash
☐ Hit guardrail/tree
☐ More than three vehicles
☐ Rollover
☐ Ran off road

You were the:

☐ Driver
☐ Front Passenger
☐ Rear Passenger

Describe the vehicle you were in

Model year and make: _____

☐ Subcompact car
☐ Full-size car
☐ Compact car
☐ Pickup truck
☐ Mid-size car
☐ Larger than 1 ton vehicle

Describe the other vehicle

☐ Subcompact car
☐ Full-size car
☐ Compact car
☐ Pickup truck
☐ Mid-size car
☐ Larger than 1 ton vehicle

Estimated crash speeds

Estimate how fast your vehicle was moving at time of crash. _____mph

Estimate how fast the other vehicle was moving at time of crash. _____mph

At the time of impact your vehicle was

☐ Slowing down ☐ Stopped ☐ Gaining speed ☐ Moving at a steady speed

At the time of impact the other vehicle was

☐ Slowing down ☐ Stopped ☐ Gaining speed ☐ Moving at a steady speed

During and after the crash, your vehicle

☐ Kept going straight, not hitting anything
☐ Kept going straight, hitting car in front
☐ Was hit by another vehicle
☐ Spun around, not hitting anything
☐ Spun around, hitting car in front
☐ Spun around, hitting object other than car

Describe yourself during the crash

Check only the areas that apply to you:

- ☐ You were unaware of the impending collision.
- ☐ You were aware of the impending crash and braced yourself.
- ☐ Your body, torso, and head were facing straight ahead.
- ☐ You had your head and/or torso turned at the time of collision:
  - ☐ Turned to left ☐ Turned to right
- ☐ You were intoxicated (alcohol) at the time of the crash.
- ☐ You were wearing a seat belt.
  If yes, does your seat belt have a shoulder harness? ☐ Yes ☐ No
- ☐ You were holding onto the steering wheel at the time of impact.

Indicate if your body hit something or was hit by any of the following:

Please draw lines and match the left side to the right side.

Head	Windshield
Face	Steering wheel
Shoulder	Side door
Neck	Dashboard
Chest	Car frame
Hip	Another occupant
Knee	Seat
Foot	Seat belt

Check if any of the following parts broke, bent, or were damaged in your car

☐ Windshield	☐ Seat frame	☐ Knee bolster
☐ Steering wheel	☐ Side/rear window	☐ Other_____
☐ Dashboard	☐ Mirror	☐ Other_____

Rear-end collisions only (answer this section only if you were hit from the rear).

Does your vehicle have:

- ☐ Movable head restraints
- ☐ Fixed, non-movable head restraints
- ☐ No head restraints

Please indicate how your head restraint was positioned at the time of the crash.*

- ☐ At the top of the back of your head
- ☐ Midway height of the back of your head
- ☐ Lower height of the back of your head
- ☐ Located at the level of your neck
- ☐ Located at the level of your shoulder blades (upper back) below neck

*Estimate the distance between the back of your head and the front of the head restraints. _____ inches

All collisions (answer this section regardless of the type of crash, indicating those items relevant to your car).

Yes	No	
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floor board of your car, dent inward during the crash?
☐	☐	Did the side door touch your body during the crash?
☐	☐	Were your hands on the steering wheel or dashboard during the crash?
☐	☐	Did your body slide under the seat belt?
☐	☐	Was a door of your vehicle damaged to the point where you could not open it?

Emergency department

Yes	No	
☐	☐	Did you go to the emergency department after the accident?
☐	☐	What is the name of the emergency department? _____
☐	☐	When did you go (date and time)? _____
☐	☐	Did you go to the emergency department by ambulance?
☐	☐	Did you or another person drive you to the emergency department?
☐	☐	Where you hospitalized overnight?
☐	☐	Did the emergency department doctor take x-rays? Check what area x-rays were taken of:
		☐ Skull ☐ Back ☐ Neck
		☐ Arm ☐ Arm ☐ Arm ☐ Arm or leg
☐	☐	Did the emergency department doctor give you pain medications?
☐	☐	Did the emergency department doctor give you muscle relaxants?
☐	☐	Did you have any cuts or lacerations?
☐	☐	Did you require any stitching for cuts?
☐	☐	Were you given a neck collar or back brace to wear?

When did you first notice any pain after injury?

☐ Immediately ☐ _____ Hours after injury ☐ _____ Days after injury

If you did not see a doctor for the first time within the first week, indicate why

Check all that apply

☐ No pain was noticed
☐ No transportation
☐ No appointment schedule available
☐ Work / home schedule conflicts

If you did not see a doctor for the first time within the first month after injury, indicate why

Check all that apply

☐ No pain was noticed
☐ No transportation
☐ I thought pain would go away
☐ I self treated with over-the-counter drugs
☐ No appointment schedule available
☐ Work / home schedule conflicts
☐ I had no insurance or money
☐ I took hot showers, used ice, heat

Have you been unable to work since injury?

☐ Yes ☐ No If yes, you were off work ☐ partially or ☐ completely

Please list dates off work: _____ to _____.

Insurance and Billing Information

Yes	No	
☐	☐	Do you have automobile personal injury protection (PIP) insurance coverage?
☐	☐	Have you reported this injury to your car insurance company?
		Insurance Company Name _____
		Phone _____
		Policy number? _____
		Claim number? _____
		Adjuster's name? _____
☐	☐	Is an attorney representing you?
		Firm Name: _____
		Phone: _____
		Attorney Name: _____
☐	☐	Did the police come to the accident scene and make a report?