



# Confidential Patient Information

Welcome

**Please Print**

Acct# \_\_\_\_\_

We want to get to know you and appreciate you filling in our forms!

Name \_\_\_\_\_ Address \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  M  F Marital Status:  M  S  D  W

Email Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Primary Care Physician (name/facility): \_\_\_\_\_

Females; are you pregnant?  Y  N Date of Last Menstrual Cycle: \_\_\_\_\_

Have you ever received chiropractic care in the past?  Y  N Last Date Treated: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Insurance (if applicable)**

If you have health insurance, we will verify any chiropractic benefits you may have.

Insurance Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policyholder: \_\_\_\_\_

Patient Name (if different than policy holder) \_\_\_\_\_

**Employer**

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Employer Phone \_\_\_\_\_

**Spouse**

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Children and Ages: \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Address \_\_\_\_\_

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

Contact phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Symptoms

1. What is your number-one problem or the one area of greatest pain? \_\_\_\_\_
  
2. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day, please circle two numbers to indicate a range of your pain.  
0 1 2 3 4 5 6 7 8 9 10
  
3. When did this problem/pain start? \_\_\_\_\_  Gradual  Sudden  Progressive
  
4. What do you think caused this problem? \_\_\_\_\_
  
5. How often do you experience the pain?  
 1-2 hours per day  About half of the day  Most of the day  The pain never goes away
  
6. How often does the pain affect your daily activities?  
 It does not affect my daily activities  I have had to change how I do things  
 I have had to stop doing some of my daily activities  I am unable to perform daily activities
  
7. What increases your pain? \_\_\_\_\_
  
8. What decreases your pain? \_\_\_\_\_
  
9. Have you ever experienced this problem before?  Y  N When? \_\_\_\_\_
  
10. List any other complaints currently bothering you and rate your pain level for each using the same scale as above.  
a) \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10  
b) \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10  
c) \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10  
d) \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10
  
11. Have you ever been involved in an automobile accident?  Y  N  
a) If yes, when? \_\_\_\_\_  
b) Were you injured?  Y  N Please explain: \_\_\_\_\_
  
12. Have you ever been injured at work?  Y  N  
a) If yes, when? \_\_\_\_\_  
b) Please explain: \_\_\_\_\_
  
13. List all medication you are currently taking (*prescribed and over the counter*) \_\_\_\_\_  
\_\_\_\_\_
  
14. List all surgeries you have had (*with date*) \_\_\_\_\_  
\_\_\_\_\_

If you have experienced any of the following conditions in the past, mark a "P" on the line provided. If you are currently experiencing any of the following conditions, please mark a "C" on the line provided. (check all that apply)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> heart attack                 | <input type="checkbox"/> stroke          | <input type="checkbox"/> bloody stools                | <input type="checkbox"/> asthma                       |
| <input type="checkbox"/> diabetes                     | <input type="checkbox"/> glaucoma        | <input type="checkbox"/> cancer                       | <input type="checkbox"/> menstrual cramping           |
| <input type="checkbox"/> difficulty with urination    | <input type="checkbox"/> anemia          | <input type="checkbox"/> diverticulosis               | <input type="checkbox"/> shortness of breath          |
| <input type="checkbox"/> prostate trouble             | <input type="checkbox"/> ulcers          | <input type="checkbox"/> chest pain                   | <input type="checkbox"/> sudden weight loss           |
| <input type="checkbox"/> AIDS                         | <input type="checkbox"/> loss of memory  | <input type="checkbox"/> general fatigue              | <input type="checkbox"/> tobacco use                  |
| <input type="checkbox"/> dizziness                    | <input type="checkbox"/> diarrhea        | <input type="checkbox"/> soreness in joints           | <input type="checkbox"/> loss of hearing              |
| <input type="checkbox"/> constipation                 | <input type="checkbox"/> muscle cramping | <input type="checkbox"/> migraine                     | <input type="checkbox"/> epilepsy                     |
| <input type="checkbox"/> nausea                       | <input type="checkbox"/> headache        | <input type="checkbox"/> syphilis                     | <input type="checkbox"/> sprained ankle               |
| <input type="checkbox"/> ears ringing                 | <input type="checkbox"/> tuberculosis    | <input type="checkbox"/> gall bladder trouble         | <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> gout                         | <input type="checkbox"/> arthritis       | <input type="checkbox"/> kidney stones                |   |
| <input type="checkbox"/> knee/hip replacement         | <input type="checkbox"/> fainting spells | <input type="checkbox"/> difficulty w/bowel movements |   |
| <input type="checkbox"/> broken bones (specify) _____ |  |   |   |

General Activities (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> sleep on waterbed                     | <input type="checkbox"/> play video games (___ hrs per day) |
| <input type="checkbox"/> read in bed                           | <input type="checkbox"/> exercise ___ x/wk.                 |
| <input type="checkbox"/> fall asleep in recliner / on couch    | <input type="checkbox"/> jog ___x/wk.                       |
| <input type="checkbox"/> sleep on stomach                      | <input type="checkbox"/> computer use (___ hrs per day)     |
| <input type="checkbox"/> needlepoint/ knitting                 | <input type="checkbox"/> swim                               |
| <input type="checkbox"/> use two or more pillows to sleep with | <input type="checkbox"/> use treadmill / elliptical mach.   |
| <input type="checkbox"/> sewing                                | <input type="checkbox"/> watch television (___ hrs per day) |
| <input type="checkbox"/> lift weights / wt. mach.              |   |

Please add anything else you would like the doctor to know: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorized the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I will make payment for my portion of charges at each visit unless other arrangements are made.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (signature of parent or guardian if the patient is a minor)

Body Diagram Date \_\_\_\_\_

Acct# \_\_\_\_\_

Last Name \_\_\_\_\_

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

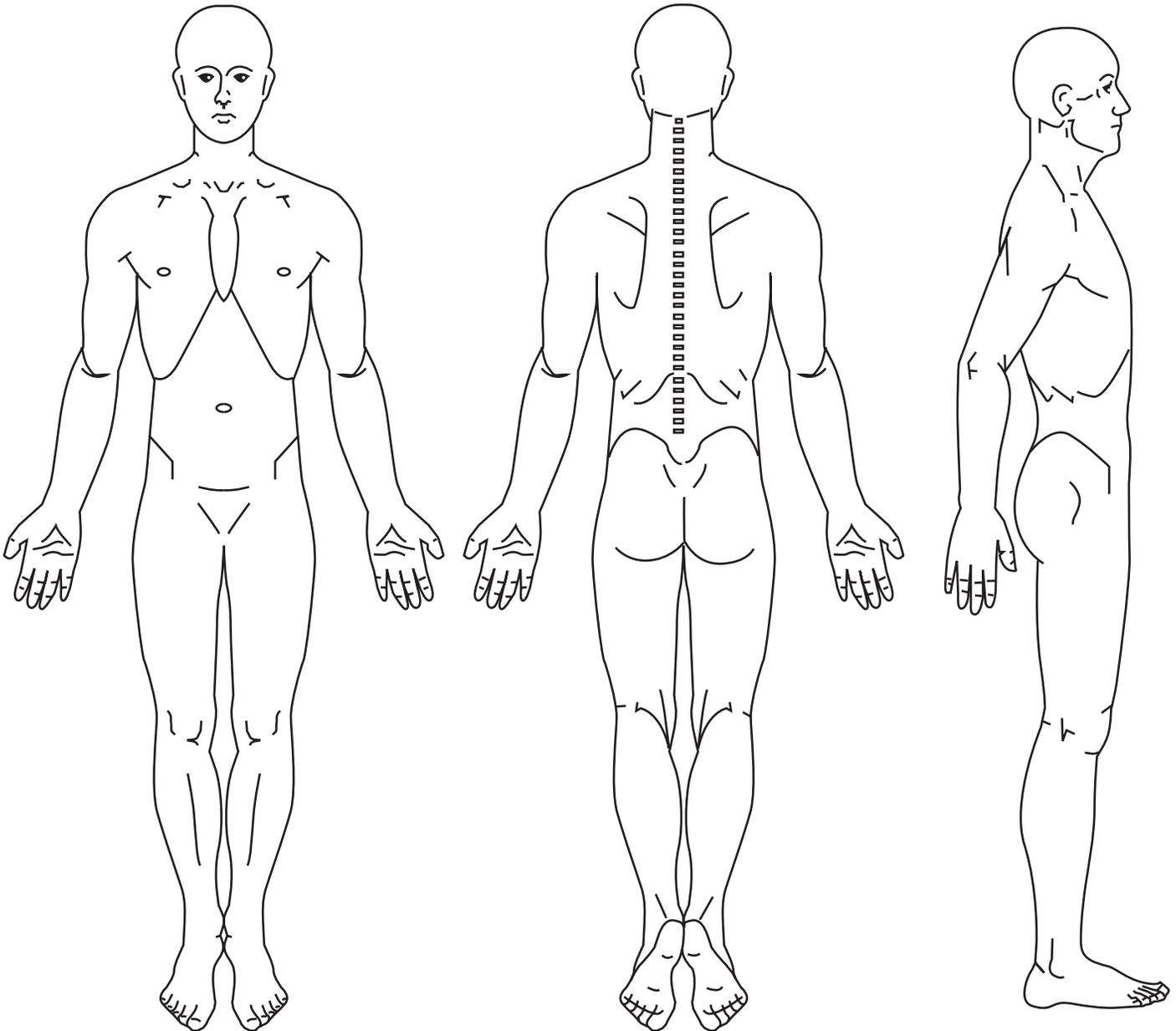
Please mark the diagrams according to where you experience your symptoms and pain using the following symbols:

**X** for Sharp Pain

**O** Dull Ache

**///** Burning Pain

**\*\*\*** Numbness



Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_



## Health Insurance Portability Accountability Act (HIPAA)

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### Health Care Information, Telephone Calls, and Open Room Treatment and Therapy

Dr. Michael Bennese and members of the Synchrony ChiroCare practice team may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Synchrony ChiroCare provides treatment and therapy in an open environment, with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed during your office visits.

Synchrony ChiroCare periodically randomly records (audio or video) selected doctor/patient communications. These recordings are used for quality control and training purposes only. By signing this form, you are giving us permission to periodically record communications you have with the doctor.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time, this is your right under Federal Law.

This notice is effective as of April 21, 2010. This authorization will expire seven years after the date in which you last received services from Synchrony ChiroCare.

I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures as indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is not promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot pack and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million person/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Print Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_