Synchrony ChiroCare
Harmony of Structure and Function

Work Accident History

Please Print

Patient Information

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 Number: _____ Primary Care Physician: _____

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? _____

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: _____

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)

Accident/Injury History

1. Date of Accident/Injury: _____ ○ Gradual ○ Sudden ○ Progressive

2. Address/Location where you were injured? _____
   _____
   No. and Street City County

3. Time of day when accident occurred: _____ am/pm Date Last Worked: _____

4. Did you report this to your employer? ○ Y ○ N If so, to whom? _____

5. Did you go to the hospital or another doctor's office after the accident? ○ Y ○ N
   If so, where: _____ Were x-rays taken? ○ Y ○ N
   What type of treatment did you receive? _____
   Was a diagnosis made? ○ Y ○ N If so, what was it? _____

6. Describe how the accident/injury happened? _____
   _____
   _____

7. What is your number-one problem or the one area of greatest pain? _____

8. Have you ever experienced this problem before? ○ Y ○ N When? _____

9. 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

10. 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

11. How does the pain affect your daily activities?
    ○ It does not affect my daily work or home activities.
    ○ I have had to change how I do my work or home activities. Please explain: _____
    ○ I cannot do the following due to my present problem: _____
    ○ I am unable to do nearly everything I am accustomed to doing.

12. What increases your pain? _____

13. What decreases your pain? _____

14. 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

15. Do you feel you could perform your usual job right now? ○ Y ○ N

16. Describe your routine job duties: _____

_____

_____

17. If you are working, how has your current condition affected your normal duties? _____

_____

_____

18. Is there any activity or duty you are unable to perform? _____

_____

_____

19. How often does your job require you to do the following:

- ○ Lifting (_____lbs) ○ Sitting (_____hrs/day) ○ Standing (_____hrs/day)
- ○ Computer (_____hrs/day) ○ Telephone (_____hrs/day) ○ Driving (_____hrs/day)

○ Push/pull:	○ Once in a while	○ Often	○ Frequently	○ Almost all the time
○ Reach overhead:	○ Once in a while	○ Often	○ Frequently	○ Almost all the time
○ Grasping:	○ Once in a while	○ Often	○ Frequently	○ Almost all the time
○ Twisting/bending:	○ Once in a while	○ Often	○ Frequently	○ Almost all the time
○ Squatting/kneeling:	○ Once in a while	○ Often	○ Frequently	○ Almost all the time
○ Walking:	○ Once in a while	○ Often	○ Frequently	○ Almost all the time
○ Climbing/ladders:	○ Once in a while	○ Often	○ Frequently	○ Almost all the time

- ○ Other Please explain:_____

20. Have you ever been injured at work prior to this accident/injury? ○ Y ○ N
    a. If yes, when? _____
    b. Please explain: _____

21. Have you ever been involved in an automobile accident before? ○ Y ○ N
    a. If yes, when? _____
    b. Were you injured? ○ Y ○ N Please explain: _____

22. List all surgeries you have had (with date) _____

_____

23. List all medication/vitamins/supplements you are currently taking (prescribed and over the counter)

_____

_____

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

_____

_____

_____

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)

__ heart attack
__ diabetes
__ difficulty with urination
__ prostate trouble
__ AIDS
__ dizziness
__ constipation
__ nausea
__ ears ringing
__ gout
__ knee/hip replacement
__ broken bones (specify) _____

__ stroke
__ glaucoma
__ anemia
__ ulcers
__ loss of memory
__ diarrhea
__ muscle cramping
__ headache
__ tuberculosis
__ arthritis
__ fainting spells

__ bloody stools
__ cancer
__ diverticulosis
__ chest pain
__ general fatigue
__ soreness in joints
__ migraine
__ syphilis
__ gall bladder trouble
__ kidney stones
__ tobacco use

__ difficulty w/bowel movements
__ asthma
__ menstrual cramping
__ shortness of breath
__ sudden weight loss
__ loss of hearing
__ epilepsy
__ sprained ankle
○ R ○ L

General Activities (check all that apply)

- ○ sleep on waterbed
- ○ read in bed
- ○ fall asleep in recliner / on couch
- ○ sleep on stomach
- ○ needlepoint/ knitting
- ○ use two or more pillows to sleep with
- ○ sewing
- ○ lift weights / weight machine
- ○ play video games (__ hrs per day)
- ○ exercise ___ x/wk.
- ○ jog ___x/wk.
- ○ computer use (__ hrs per day)
- ○ swim
- ○ use treadmill / elliptical machine
- ○ watch television (__ hrs per day)

Authorization

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.

Patient's Signature _____ Date _____
(signature of parent if the patient is a minor)

Doctor's Comments:_____

_____

_____

_____

_____

Synchrony ChiroCare

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Pain Diagram

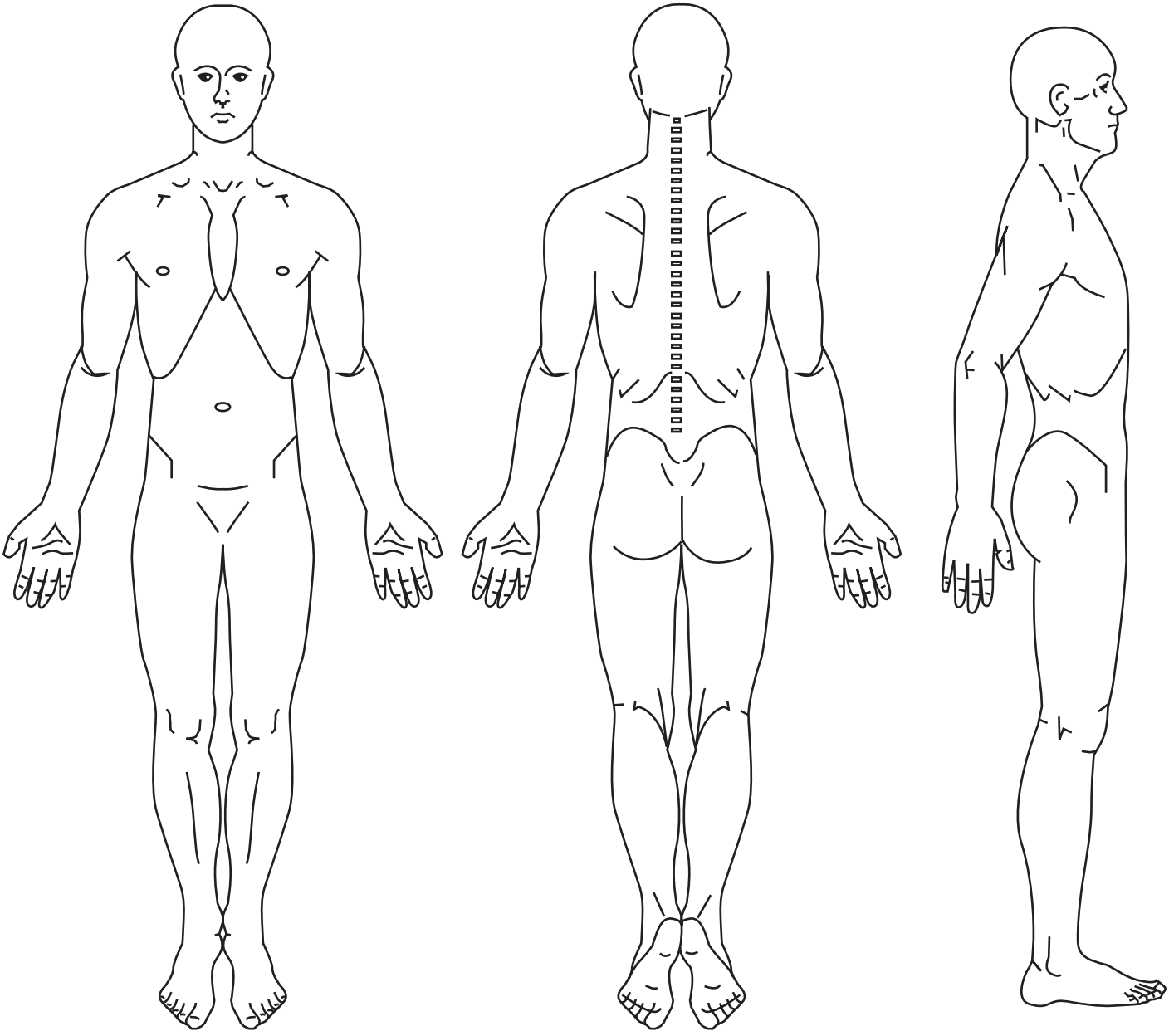
Please Print

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 _____

Synchrony ChiroCare

Harmony of Structure and Function

Health Insurance Portability Accountability Act (HIPAA)

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 there of 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 cause 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 on 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: _____