Welcome to Cynergy

Patient Information

Thank you for choosing our practice.

Name_____ Date_____ S.S.#_____
First MI last
Address _____ City_____ State_____ Zip _____

Sex: Female Male Birth date _____E-Mail _____

Home Phone #:_____ Work Phone#:_____ Cell Phone#:_____

Are you: Minor Single Married Partner Divorced Other _____

Your Employer: _____ Occupation: _____

Business Address_____ City _____ State_____ Zip_____

Spouse's or parent's name _____ Workplace_____ Phone #_____

Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone #_____

Responsible Party:
Name of person responsible for this account _____
Relationship to patient _____ Phone #_____
Address _____ City _____ State _____ Zip_____
Name of employer:_____ Work Phone #:_____

Insurance Information:
If you have any insurance information please provide the staff with your insurance card and/or necessary forms. Thank you.

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 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 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.
    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 When? _____
    Were you injured? [ ] Y [ ] N Explain: _____
12. Have you ever been injured at work? [ ] Y [ ] N When? _____
    Explain: _____
13. List all medications you are currently taking (prescribed and over the counter):
    _____
14. List all surgeries you have had: _____

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 ___ stroke ___ arthritis ___ gall bladder trouble ___ diabetes ___ glaucoma
___ fainting spells ___ kidney stones ___ difficulty with urination ___ bloody stools
___ difficulty with bowel movements ___ prostate trouble ___ anemia ___ cancer ___ asthma
___ ulcers ___ diverticulosis ___ menstrual cramping ___ dizziness ___ loss of memory
___ shortness of breath ___ constipation ___ diarrhea ___ general fatigue ___ sudden weight loss
___ nausea ___ muscle cramping ___ soreness in joints ___ loss of hearing ___ ears ringing
___ headache ___ migraine ___ epilepsy ___ gout ___ tuberculosis ___ syphilis ___ AIDS
___ sprained ankle [ ] R [ ] L ___ knee/hip replacement ___ broken bones ___ chest pain

General Activities: (Check all that apply.)

___ sleep on waterbed ___ read in bed ___ fall asleep in recliner/on couch ___ sewing
___ needlepoint/knitting ___ use two or more pillows to sleep ___ sleep on stomach
___ lift weights/wt. mach. ___ play video games (_____ hrs per day) ___ exercise _____x/wk
___ jog _____x/wk ___ computer use (_____ hrs per day) ___ swim ___ use health rider
___watch television (_____ hrs per day)

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

Authorization:

I certify that I have read and 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: _____
_____