

Synergy Chiropractic and Wellness Clinic
2177 Troop Drive Sartell MN 56377

Legal Information:

Today's Date _____
Legal Name _____ Nick Name _____
Permanent Address _____ City _____ State _____ Zip _____
Temporary Address (EX: college students) _____ City _____ State _____ Zip _____
SSN _____ - _____ - _____ Home Phone _____ - _____ - _____ Wk Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____
Birthdate ____/____/____ Age: _____ Gender: Male _____ Female _____ Email _____
Emergency Contact _____ Phone _____
May we contact you at work to verify appointment or insurance information: _____ Yes _____ No
Would you like to receive reminders for appointments via: e-mail Text **carrier** _____ or phone call

Personal Information:

Your Physician's Name: _____ Clinic Name: _____
Previous Chiropractor's Name _____
Have you ever been in an automobile accident? Yes _____ No _____ If so, when? _____

Marital Status

_____ Single _____ Married _____ Legally Separated _____ divorced _____ Widowed _____ Other _____

Family

Spouse/Partner's Name _____ Children/Ages _____

Referred By

Friend _____, Health Fair _____, Yellow Pages _____ internet _____
Doctor _____, MD/DC from _____ Clinic _____
Insurance Book _____ Other _____

Employment

_____ Full Time _____ Part Time _____ Retired _____ Unemployed _____ Specify Other _____
Employer _____ Occupation _____
Address of Employer _____ City _____ State _____ Ph # _____ - _____ - _____

Insurance Information:

Primary Insurance Company _____ Policy Holder's Name _____
Policy Holder's Date of Birth ____/____/____ Policy Holder's Employer _____
Relationship to Policy Holder: _____ self _____ spouse _____ child _____ other _____
Secondary Insurance Company _____ Policy Holder's Name _____
Policy Holder's Date of Birth ____/____/____ Policy Holder's Employer _____
Relationship to Policy Holder: _____ self _____ spouse _____ child _____ other _____

Has a Worker's Compensation Claim Been Filed for this injury? _____ Yes _____ No
Has an Auto Accident Claim Been filed for this Injury? _____ Yes _____ No
Date of Work Injury or Auto Accident ____/____/____

Please present your insurance card and driver's license to the reception desk so that we can make a photo copy for your file. Thank you.

Office Policies

1. We are providers for numerous health care insurance policies. For your convenience we will verify your insurance benefits and submit claims as a courtesy to you. However, your insurance is a contract between you and your insurance company. You are fully responsible for all charges due to services rendered. If payment is denied for any reason by your insurance company, you are then responsible for full payment of those services.
2. Copays must be paid at the time of service. For patients who do not have insurance, we offer a 10% discount if you pay the same day. If you are unable to pay in full, we require you to set up a payment plan with our monthly credit card guarantee program.
3. We send out monthly statements to our patients, after your insurance company has processed the claim for your visit. We require that the balance be paid in full within 90 days, or a credit card be kept on file with a monthly payment plan set up. If the account becomes delinquent after 90 days (no payment received), your account will be turned over to a collection agency.
4. Any insurance payments paid directly to you by your insurance company, must be turned over to our office with- in 1 week.
5. You are required to pay for items not covered by your insurance company at the time of service. (Kinesiotape, supplements, oils, hot/cold packs, etc.) Unopened items may be returned within 15 days of purchase, except homeopathics.

Cancellation Policy

As a courtesy we ask that you give 24 hours notice when cancelling your chiropractic and massage appointments. No shows for massage or last minute cancellations will be charged a \$20.00 fee. You may then be asked to reserve subsequent massage appointments with a credit card.

I have read and understand the above statements:

Patient Signature _____ Date _____

Chiropractic Consent

Any procedure intended to help, may also do harm. While chiropractic and therapeutic procedures (e.g. spinal adjustments, ultrasound, heat and cold applications, electrotherapy, and manual muscle therapy) are considered remarkably safe and effective, please understand that occasionally there may be adverse reactions.

Although the chances of experiencing any of these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients. These complications include, but are not limited to:

- | | | | | | | |
|-------|----------|---------------|-------------|----------|---------------|-----------------|
| Pain | Swelling | Inflammation | Disc Injury | Nausea | Dizziness | Stroke |
| Burns | Bruising | Discoloration | Weakness | Bleeding | Bone Fracture | Sensory Changes |

Worsening of condition Spinal cord damage

I understand there is no guarantee or warranty for a specific cure or result. I understand that I can request further explanation regarding any and all possible attendant to my care.

Patient Signature: _____ Date: _____ Doctor Signature: _____

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 HIPAA NOTICE that is available to you at the reception desk before signing this consent.

1. The patient understands and agrees to allow Synergy Chiropractic and Wellness Clinic 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 obtained 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 privacy official has been designated to enforce those 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 the right to file a formal complaint with our privacy official 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 chiropractic physician has the right to refuse to give care.

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

Patient Signature: _____ Date: _____

CONSENT TO TREAT A MINOR

I, _____ (parent/guardian) give my permission to Dr. Cheri Carlson at Synergy Chiropractic and Wellness Clinic to give spinal adjustment/manipulations and necessary therapies to _____ (child's name), _____ (DOB).

Parent/Guardian Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ Date: ____/____/____

Describe your symptoms: _____

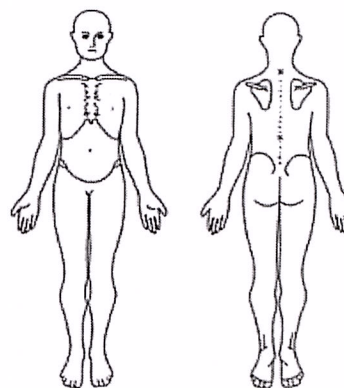
When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms:



What describes the nature of your symptoms?

- Sharp
- Shooting
- Dull Ache
- Burning
- Numb
- Tingling

How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None 1 2 3 4 5 6 7 8 9 10 Unbearable

b. How much has pain interfered with your normal work
 (including both work outside the home, and housework)

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc.)

- All of the time
- Most of the time
- Some of the time
- None of the time

In general would you say your overall health right now is.....

- Excellent
- Very Good
- Good
- Fair
- Poor

Who have you seen for your symptoms?

- No One
- Chiropractor
- Medical Doctor
- Physical Therapist
- Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

- X-rays: date: _____
- CT Scan: date: _____
- MRI: date: _____
- Other: date: _____

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** ____ / ____ / ____

Height: ____ft ____in

Weight: _____ lbs.

What type of regular exercise do you perform?

None

Moderate

Light

Strenuous

Check any conditions/symptoms past or present that may apply to you:

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> Headaches | <input checked="" type="checkbox"/> Bladder Infection | <input checked="" type="checkbox"/> Allergies |
| <input checked="" type="checkbox"/> Neck Pain | <input checked="" type="checkbox"/> Painful Urination | <input checked="" type="checkbox"/> Depression |
| <input checked="" type="checkbox"/> Upper Back Pain | <input checked="" type="checkbox"/> Loss of Bladder Control | <input checked="" type="checkbox"/> Systemic Lupus |
| <input checked="" type="checkbox"/> Mid Back Pain | <input checked="" type="checkbox"/> Prostate Problems | <input checked="" type="checkbox"/> Epilepsy |
| <input checked="" type="checkbox"/> Low Back Pain | <input checked="" type="checkbox"/> Abnormal Weight Gain/Loss | <input checked="" type="checkbox"/> Dermatitis/Eczema/Rash |
| <input checked="" type="checkbox"/> Shoulder Pain | <input checked="" type="checkbox"/> Loss of Appetite | <input checked="" type="checkbox"/> HIV/AIDS |
| <input checked="" type="checkbox"/> Elbow/Upper Arm Pain | <input checked="" type="checkbox"/> Abdominal Pain | <input checked="" type="checkbox"/> Birth Control Pills |
| <input checked="" type="checkbox"/> Wrist Pain | <input checked="" type="checkbox"/> Ulcer | <input checked="" type="checkbox"/> Hormonal Replacement |
| <input checked="" type="checkbox"/> Hand Pain | <input checked="" type="checkbox"/> Hepatitis | <input checked="" type="checkbox"/> Pregnancy |
| <input checked="" type="checkbox"/> Hip/Upper Leg Pain | <input checked="" type="checkbox"/> Liver/Gall Bladder Disorder | <input checked="" type="checkbox"/> Rheumatoid Arthritis |
| <input checked="" type="checkbox"/> Knee/Lower Leg Pain | <input checked="" type="checkbox"/> Cancer | <input checked="" type="checkbox"/> General Fatigue |
| <input checked="" type="checkbox"/> Ankle/Foot Pain | <input checked="" type="checkbox"/> Tumor | <input checked="" type="checkbox"/> Muscular Incoordination |
| <input checked="" type="checkbox"/> Jaw Pain | <input checked="" type="checkbox"/> Asthma | <input checked="" type="checkbox"/> Visual Disturbances |
| <input checked="" type="checkbox"/> Joint Swelling/Stiffness | <input checked="" type="checkbox"/> Chronic Sinusitis | <input checked="" type="checkbox"/> Dizziness |
| <input checked="" type="checkbox"/> Arthritis | <input checked="" type="checkbox"/> Diabetes | <input checked="" type="checkbox"/> High Blood Pressure |
| <input checked="" type="checkbox"/> Heart Attack | <input checked="" type="checkbox"/> Excessive Thirst | <input checked="" type="checkbox"/> Other Health Problems/Issues: _____ |
| <input checked="" type="checkbox"/> Chest Pains | <input checked="" type="checkbox"/> Frequent Urination | _____ |
| <input checked="" type="checkbox"/> Stroke | <input checked="" type="checkbox"/> Smoking/Use Tobacco Products | _____ |
| <input checked="" type="checkbox"/> Angina | <input checked="" type="checkbox"/> Drug/Alcohol Dependence | _____ |
| <input checked="" type="checkbox"/> Kidney Stones | | |
| <input checked="" type="checkbox"/> Kidney Disorders | | |

Indicate if an immediate family member has had any of the following:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Rheumatoid Arthritis | <input checked="" type="checkbox"/> Cancer |
| <input checked="" type="checkbox"/> Heart Problems | <input checked="" type="checkbox"/> Lupus |
| <input checked="" type="checkbox"/> Diabetes | <input checked="" type="checkbox"/> Other: _____ |

What do you hope to get from your visit/treatment? (select all that apply)

- Reduce Symptoms Resume/Increase Activity Explanation of condition/treatment
- Learn how to take care of this on my own How to prevent this from occurring
- Other: _____

List ALL prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List ALL surgical procedures you have had and times you have been hospitalized:

Patient Signature: _____ **Date:** ____ / ____ / ____

Neck Index

Form N1-100

rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- Ⓐ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- Ⓐ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- Ⓐ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- Ⓐ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- Ⓐ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- Ⓐ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- Ⓐ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- Ⓐ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

Back Index

Form BI100

rev 3/27/2003

Patient Name _____ Date _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score