Cynergy Chiropractic Center
Dr. Peter Eisenhauer, D.C.
Julie Johnson, L.Ac.

Welcome to Cynergy Chiropractic Intake

Patient Information

Thank you for choosing our practice.

Name:_____ Date:_____
First MI Last

Address: _____ City_____ State_____ Zip _____

Gender: Male Female Non-Binary Trans Pronouns: He/Him She/Her They/Them

Birth date: _____ E-Mail: _____

Cell Phone #:_____ Other Phone#:_____

Are you: Minor Single Married Partner Divorced Other _____

Your Employer:_____ Occupation:_____

Business Address:_____ City _____ State_____ Zip_____

Whom may we thank for referring you to us? _____

Emergency Contact: _____ Phone #_____

Relationship:_____

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.

Have you had Chiroptractic Care in the past?

Yes NO

If yes, how long ago?:_____ Frequency?_____

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: _____
    _____

Patient History: 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
___ difficult urination	___ bloody stools	___ diverticulosis	___ difficult bowel movements
___ prostate trouble	___ anemia	___ cancer	___ asthma
___ ulcers	___ dizziness	___ loss of memory	___ menstrual cramping
___ shortness of breath	___ constipation	___ diarrhea	___ general fatigue
___ sudden weight loss	___ nausea	___ headache	___ migraine
___ muscle cramping	___ soreness in joints	___ loss of hearing	___ ears ringing
___ epilepsy	___ gout	___ tuberculosis	___ syphilis
___ HIV	___ broken bones	___ chest pain	

Family History: If any of your family members have experienced any of the following conditions listed, please also mark the condition with an "F" on the line provided (Check all that apply.)

___ heart attack	___ stroke	___ arthritis	___ gall bladder trouble
___ diabetes	___ glaucoma	___ fainting spells	___ kidney stones
___ difficult urination	___ bloody stools	___ diverticulosis	___ difficult bowel movements
___ prostate trouble	___ anemia	___ cancer	___ asthma
___ ulcers	___ dizziness	___ loss of memory	___ menstrual cramping
___ shortness of breath	___ constipation	___ diarrhea	___ general fatigue
___ sudden weight loss	___ nausea	___ headache	___ migraine
___ muscle cramping	___ soreness in joints	___ loss of hearing	___ ears ringing
___ epilepsy	___ gout	___ tuberculosis	___ syphilis
___ broken bones	___ chest pain		

General Activities: (Check all that apply.)

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

Neurodivergences: (Check all that apply)

___ ADHD ___ Autism Spectrum Disorder ___ Intellectual Disability ___ OCD

___ Sensitivities: _____

___ Other: (please list how we can support) _____

_____

_____

Mental Health Considerations: (Check all that apply)

___Anxiety ___ Depression

___Other: _____

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

Spinal Decompression Consent:

(This treatment will not apply to everyone and if the doctor thinks that it is necessary if will be discussed with a trial prior to being charged.)

Spinal Decompression is a non-surgical and drug-free answer for disc related syndromes of the lumbar or cervical spine. Many people across the country have found relief from the pain associated with herniated discs, bulging discs, facet syndrome, degenerative joint disease, pinched nerves, and other spinal afflictions. This FDA-cleared technology relieves pain by enlarging the space between the discs. Spinal Disc Decompression uses computer-aided technology to apply gentle, non-surgical, decompression to your spine, increasing circulation into the spinal discs and joints, thus helping to relieve the symptoms that cause pain and dysfunction.

Please note that Spinal Decompression is **not covered by insurance**. Unfortunately, we cannot bill your insurance company for Spinal Decompression because it is not a billable code. Therefore, Spinal Decompression is an additional $35.00 per visit on top of your usual and customary fee.

By signing below, you understand the above information and agree to the additional fee.

Patient's Signature:_____Date_____

Financial 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: _____

_____

INFORMED CONSENT

A patient coming to the doctor gives him/her permission and authority to care for him/her in accordance with appropriate testing, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal, or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I, the undersigned patient, agree to settle any claim or dispute I may make against or with any of these persons or entities, whether related to the prescribed care or otherwise. I understand that any claim or dispute will be resolved by binding arbitration under the current malpractice terms, which can be obtained by written request.

Patient's Signature: _____

Date: _____

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal; yet, in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health, and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to chiropractic care, including spinal adjustments, as reported following my assessment.

Patient's Signature: _____

Date: _____

HIPAA: Consent for Purposes of Treatment, Payment, and Health Care Operations

I, _____, hereby consent to the use or disclosure of my protected health information by Cynergy Chiropractic Center, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Cynergy Chiropractic Center, Inc.

I understand that diagnosis or treatment of me by Cynergy Chiropractic Center, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Cynergy Chiropractic Center, Inc. is not required to agree to the restrictions that I may request. However, if Cynergy Chiropractic Center, Inc. agrees to a restriction that I request, the restriction is binding on Cynergy Chiropractic Center, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent Cynergy Chiropractic Center, Inc. has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created and received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Cynergy Chiropractic Center, Inc.'s Notice of Privacy Practices prior to signing this document.

Cynergy Chiropractic Center, Inc.'s Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Cynergy Chiropractic Center, Inc.

The Notice of Privacy Practices also describes my rights and the duties of Cynergy Chiropractic Center, Inc. with respect to my protected health information.

Cynergy Chiropractic Center, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority