Synergy Chiropractic & Physical Therapy
31360 Via Colinas Dr. Suite 104 Westlake Village, CA 91362
805 – 492 – 1500

Patient Registration and History Questionnaire

Name:_____ Age:_____ Date of birth:_____ Date: _____
LAST FIRST MIDDLE

Address:_____ ... Male ... Female

City, State, Zip:_____ Marital Status: ... M ... S ... W ... D # of Children_____

Home Phone (_____)_____ Work Phone (_____) _____

Email: _____

Employer:_____ Spouse's Name: _____

Who can we thank for referring you? _____

In case of emergency, notify_____ **Relationship:**_____ **Phone (_____)** _____

Chief Complaint or Reason for Office Visit: _____

Specific Date and Time of Onset of Symptoms: _____

What makes your symptoms **better**?_____ What makes your symptoms **worse**? _____

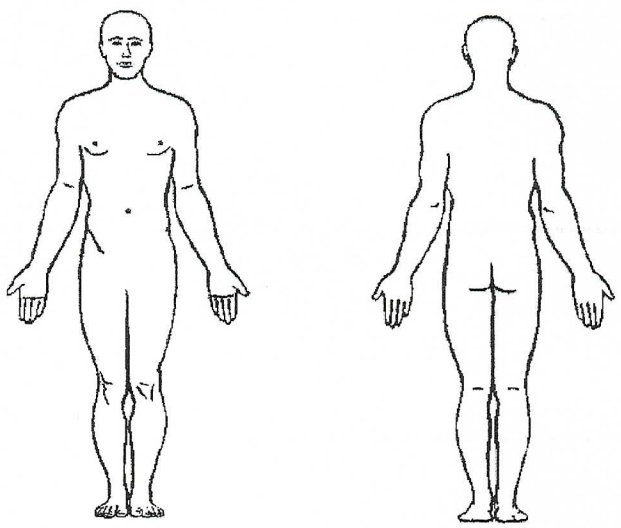
What is the quality of your symptoms? (**ache, burn, dull, sharp, throbbing**): _____

Are your symptoms local or do they travel to another area? (If they travel, towhere?) _____

Are symptoms; ...Constant >76% ...Frequent 51-75% ...Occasional 26-50% ...Intermittent <25% **of your waking hours**

Please mark on the diagram to the right the following symbols as they relate to your symptoms:

SS = spasms
ST = stiffness
DP = dull pain
SP = sharp pain
SH = shooting pain
TI = tingling
NU = numbness
O = Other



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Please list all medications and dosage:	**Frequency**	**For What Illness?**

List any allergies to medications, foods or other: _____

Are you pregnant? ... **Yes** ... **No** First day of last menstrual cycle: _____

Do you smoke? ... Yes ... No; How much?_____Do you drink alcohol? ... Yes ... No; How much? _____

Primary Care Physician: _____

Please list all serious illness and serious accidents:	**Month and Year**	**City, State**

Please list any recent x-rays, lab or other tests:	**Date**	**Facility/Doctor**

Please list any surgeries:	**Date**	**Facility/Doctor**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis ... Yes	Lung Disease ... Yes	Gout ... Yes	Diabetes ... Yes
Kidney Disease ... Yes	Stomach/Ulcer ... Yes	Heart Disease ... Yes	Hepatitis ... Yes
Sciatica ... Yes	Blood Pressure ... Yes	Transfusion ... Yes	Polio / MS ... Yes
Colon Disease ... Yes	Stroke ... Yes	Cancer ... Yes	Bleeding ... Yes
Paralysis ... Yes	Seizures ... Yes	Arthritis ... Yes	Asthma ... Yes
Anemia ... Yes	Thyroid Disease ... Yes	Drug Dependence ... Yes	AIDS ... Yes

Any other condition(s) not listed above that the doctor should be made aware of:

_____

_____

_____

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Informed Consent
To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:
The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment
As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Range of Motion Testing
- Orthopedic Testing
- Basic Neurological Testing
- Muscle Strength Testing
- Ultrasound
- Hot/Cold therapy
- Posture Analysis Test
- EMS
- Other: all physiotherapy in the office including but not limited to laser, PEMF, compression boots, traction, etc...

The risks inherent in chiropractic adjustment:
As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring:
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options:
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated:
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

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DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW:

_____ I have read OR _____ I have had read to me:
The above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(the doctor and/or staff)* and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name (print)_____
Patient's Signature _____ Date _____

PHYSICAL THERAPY

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. C.P.P.T. does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with you treating physical therapist throughout your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Patient Name (print)_____
Patient's Signature _____ Date _____

HIPAA Compliance

Synergy Chiropractic & Physical Therapy is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: Date: _____
Witness: Date: _____
Staff Initials: _____

Consent for Treatment of a Minor

I hereby authorize all Synergy Chiropractic and Physical Therapy employees to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter _____.
Guardian Name (print): _____
Guardian Signature: _____ Date: _____

Missed Appointment Charge

There will be a charge for a missed appointment with less than 24-hour notice. This includes:

No show

Cancellation

Reschedule

I understand that if I cannot make the appointment, I will call at least 24 hours before the appointment or I will be charged a $30 fee. This fee must be paid over the phone or before any future visit.

Name: (Printed) _____ Date: _____

Signed _____

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