Synergy Health & Wellness

PERSONAL INFORMATION

Name:	Date of Birth:
Address:	
City: State Zip	**Email:**
Home# Work#	Cell#

Non-Florida Address:

City: State Zip

Phone #

Gender: Male Female *(circle)*	Soc. Sec.#:
Marital Status: Single Married	Widowed Divorced *(circle)*
Referring Physician:	Last MD Appointment:
Emergency Contact:	Ph#

How did you hear about us?

Statement of Financial Responsibility

Primary Insurance:	Policy#
Secondary Insurance:	Policy#
Attorney Name (if liability case)**:**	Phone#

I understand that **I am responsible for payment** to Synergy Health and Wellness for anything my insurance does not cover. This includes any deductibles, co-payments, and coinsurance as determined by my contract with my insurance carrier. If my insurance denies payment for any reason, this will also be my responsibility to pay for services rendered by Synergy Health and Wellness. I will be responsible for all collection and court costs for any unpaid balance on my account. (Does not apply for worker's compensation cases)

Signature: **Date:**

Relationship to patient: Self Guardian Parent Other: _______________

Consent of Treatment and Authorization to Release Information & Privacy Practices Acknowledgement

I give consent to Synergy Health and Wellness to perform the services required to treat my condition. In addition, I hereby authorize Synergy Health and Wellness through its appropriate personnel, to bill for services rendered to me, or the above named patient, all services relating to my therapy. I further authorize Synergy Health and Wellness to release to appropriate agencies, any information acquired in the course of my or the above named patient's treatment, in order to pay my claims. Furthermore, I have received the Notice of Privacy Practices and have had the opportunity to review it and ask questions.

Signature: **Date**:

Relationship to patient: Self Guardian Parent Other:

Name:____ **Date:**

Allergies (circle): latex, coconut oil, beeswax, tape adhesives, __________________________________

Pregnant **Yes No** ***Smoker*** **Yes No** ***Pacemaker*** **Yes No** ***Caffeine*** **Yes No**

I Have Recently Experienced (Past 6 months, please check all that apply to you)

☐ Fatigue	☐ Bowel or Bladder Changes	☐ Constipation
☐ Fever/chills/sweats	☐ Muscle weakness	☐ Diarrhea
☐ Nausea/vomiting	☐ Dizziness/lightheadedness	☐ Shortness of breath
☐ Weight loss/gain	☐ Heartburn/indigestion	☐ Fainting
☐ Imbalance with walking, Falls	☐ Difficulty swallowing	☐ Cough
☐ Numbness or tingling	☐ Malaise	☐ Headaches
☐ Pulse Abdomen	☐ Open Wounds	☐ Bloody sputum

Past Medical History (Check all that apply to you and write others not listed)

☐ Cancer	☐ Pneumonia	☐ Thyroid Problems
☐ Heart Disease/Problems	☐ Lung Problems	☐ Diabetes
☐ Chest Pain/Angina	☐ Tuberculosis	☐ Osteoporosis
☐ High Blood Pressure	☐ Asthma	☐ Multiple Sclerosis
☐ Circulation Problems	☐ Rheumatoid Arthritis	☐ Seizures
☐ Blood Clots	☐ Osteoarthritis	☐ Chemical Dependency
☐ Stroke/mini-Stroke	☐ Bladder/Urinary tract infection	☐ Ulcers
☐ Anemia	☐ Kidney Problem/Infection	☐ Liver Problems
☐ Bone or Joint Infection	☐ Sexually transmitted disease/HIV	☐ Hepatitis
☐ Depression	☐ Endometriosis	☐ Visual Problems
☐ Hearing Loss	☐ NSAID Sensitivity	☐ Hemophilia

Other: ____

Surgical History (Please check all that apply and write others not listed)

☐ Total Knee Replacement	☐ Appendectomy	☐ Cervical Fusion
☐ Total Hip Replacement	☐ Tonsillectomy	☐ Lumbar Fusion
☐ Total Shoulder Replacement	☐ Hysterectomy	☐ Colon Resection
☐ Cataracts	☐ C-Section	☐ Hernia Repair

☐ Other ____

Family History (parents and siblings, check all that apply)

☐ Cancer	☐ Diabetes	☐ Tuberculosis
☐ Heart Problems	☐ Stroke	☐ Thyroid Problems
☐ High Blood Pressure	☐ Depression	☐ Blood Clots

All Medications, Supplements, Vitamins (Please list names only, write none if taking nothing)

____

Over the past month, have you often been bothered by feeling down, depressed or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, but not today NO

Name:____ **Date:**

Date of injury/onset: _____/_____/________ **Have you had these symptoms before**? ☐ Yes ☐ No

Date of next doctor visit: _____/_____/_____ **Are you presently working**? ☐ Yes ☐ No ☐ Limited Duty

Reason for injury or problem:

☐ Recent hospitalization ☐ Recurrence of previous injury ☐ Work related injury
☐ Motor vehicle accident ☐ Injury related to lifting ☐ Injury related to falling
☐ Cause unknown ☐ Athletic/recreational injury ☐ Other

Have you had any tests done for this condition (xrays, MRI, CT scan, bloodwork, etc) ☐ Yes ☐ No

My symptoms are worst (check any) ☐ Morning ☐ Afternoon ☐ Night ☐ After Exercise ☐ N/A

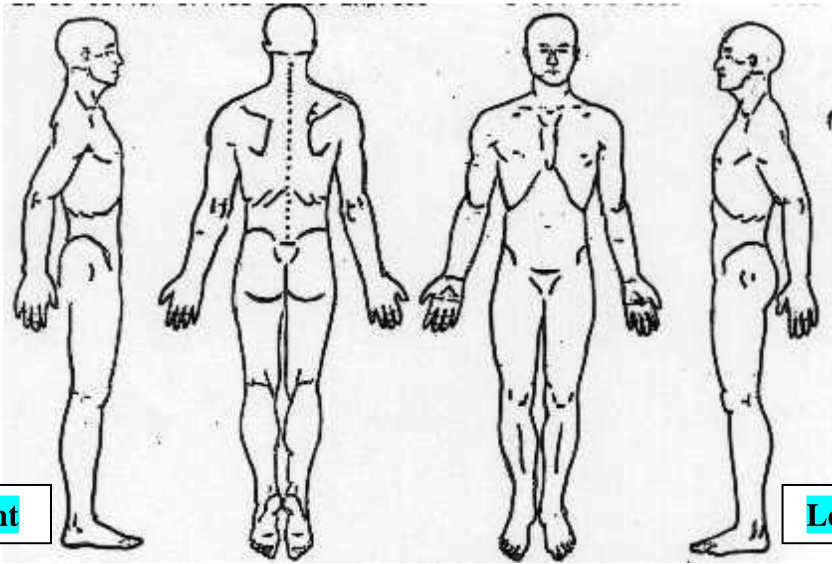
My symptoms are best (check any) ☐ Morning ☐ Afternoon ☐ Night ☐ After Exercise ☐ N/A

My symptoms are currently: ☐ Improving ☐ Unchanged ☐ Getting Worse

Do you sleep well (more than 6 hours uninterrupted)? ☐ Yes ☐ No **Why?**_______________________________

KEY
Using the symbols and descriptors below place the symbols on the body diagram that fit your symptoms right now
/// Stabbing/Shooting
XXX Dull/Achy/Burning
OOO Tingling/Pins & Needles
ΔΔΔ Numbness

Right



Left

Aggravating Factors: What makes you feel worse?

____

Easing Factors: What makes you feel better?

____

On the scale below, circle the number that best describes your pain severity for the stated time frame

Current Level of Pain												
No Pain	0	1	2	3	4	5	6	7	8	9	10	**I Need to Go to Hospital**
Worst Level of Pain for Past Week												
No Pain	0	1	2	3	4	5	6	7	8	9	10	**I Need to Go to Hospital**
Best Level of Pain for Past Week												
No Pain	0	1	2	3	4	5	6	7	8	9	10	**I Need to Go to Hospital**

Cancellation Policy for Pilates, PT, OT, Massage and Acupuncture Appointments

Updated 1/1/2015

You can cancel any visit by giving notice up to the end of the prior business day (5 PM) for any upcoming appointment. Your notice must reach an employee of Synergy Health and Wellness.

***** Messages left on our phone machine, email, or fax will only be considered accepted if we respond back to you that the message was received.**

Case 1: You have a Wednesday appointment at 8 AM. You can cancel the Wednesday appointment up until 5 PM on Tuesday and incur no charge.

Case 2: you have a Friday appointment at 5 PM. We do not hear from you. You indicate you left a message on our answering machine, but did not hear from us. We have no record of a message. You are charged a cancellation fee.

Case 3: you have a 10 AM pilates class and call to cancel at 8 AM the same day. A group class will be deducted from your account or, if you are currently on an unlimited group pilates package, you will be charged $20.

Therapy Cancellation and No Show fee is $30

Pilates Cancellation and No Show fee is 1 Pilates Class for Group

Class Packages or $20 for an unlimited package

This is not paid by insurance, it is the responsibility of the patient/client and will be collected at the next treatment session that you attend or will be mailed to you if you do not continue your therapy with us.

____ __________________________

I acknowledge receipt and agree to the terms of this policy Date