Synergy Chiropractic New Patient Intake Form

Patient Information ***Today's Date:***___________________

Please Print
First Name _________________________ Last Name ________________________________
DOB ________________________________ Sex M F SS# _______________________
Marital Status: _________ # of Children: _________ Occupation: ______________________
Street Address____
City____ State______ Zip__________
Cell Phone _________________________________ Other phone ______________________
E-mail ____
Emergency contact: ______________________ Emergency Relation ________________ Emergency Phone ____________
How did you hear about us? ____
Who is your primary care physician? ____
Date and reason for last doctor visit? ____
Health Insurance __________________________ Spouse's name ___________________

What health condition(s) bring you into our office?_______________________________
When did it start?_________________**Getting Worse?**_______**Getting Better?**_______
What makes the problem better? ____
When makes the problem worse?_________________
Rate the pain - (0 is no pain - 10 is unbearable pain) **1 2 3 4 5 6 7 8 9 10**
Other Chiropractors? _________________ **Positive Experience?** _________________
Have you seen other health care providers for this condition? Y N Who? ___________

What's your current emotional/mental stress level? High Medium Low None
Dr Mintz will recommend nutritional supplements – are you willing to take them? Y N
List ALL Medications you are currently taking _________________________________
____
Exercise frequency? ______________ **What type?** ______________________________
What supplements do you take?____
How much do you smoke per day?___________ **Drinks per week?** ________________
How many hours a day do you spending sitting at a desk or on a computer? __________
How do you sleep? Back Side Stomach **How do you wake up?** Refreshed Stiff and tired

*All above questions have been answered accurately, and I understand that giving incorrect information can affect my health situation and be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers

Acknowledgement and Consent: I understand that I am responsible for my initial visit fee of $150 which covers my consultation and exam and authorize Synergy Chiropractic and Dr. Eric Mintz to charge the credit card listed below for today's visit and for any and all subsequent visits including charging my card $55 for any and all missed visits.

Credit Card Number ____

Expiration Date: _____________ **CVV** ____________ **Billing Zip Code** ___________

Patient Printed Name ____

Patient Signature___________________________________ **Date**_______________