



Welcome To Our Office!

About Dr. Chase Hayden, DC, QN, ACN, PAK and Dr. Reece Hayden, DC, ACN, QN Intern, Acupuncturist:

We are Holistic Practitioners. We specialize in Complementary and Alternative Medicine through the use of Clinical Nutrition, Quantum Neurology Rehabilitation, Professional Applied Kinesiology, Acupuncture, and Chiropractic care. These techniques create a focus on a drug-free, non-surgical approach to the individual patient. Our vision is to guide and mentor patients to achieve their health and wellness goals through supporting the underlining cause of the patient's symptoms.

At your appointment:

We appreciate the fact that our patients have schedules to maintain, so **we do our best to run on time**. This insures that you know when your appointment begins and ends and can make plans accordingly. This also insures that you get the full time with the doctor. In order to maintain scheduled office appointments, nutritional and rehabilitative office sessions are not performed in the same appointment.

Cancellation Policy:

If for some reason you have to reschedule or cancel your existing patient appointment we do ask that you give us **24 hours notice**. (If we do not answer the phone, please leave a message because the machine will identify the date and time that you called.) By giving us 24 hours notice, it allows us to fill the spot with another patient on our waiting list. If we do NOT receive 24 hours notice you could be subject to a percentage of the scheduled visit that was missed. (\$50 for existing patient, \$150 for new patient)

Office Fees:

Our fees are based on the time that you spend with the doctor and services rendered. A new patient office visit is approximately 1-1.5 hours with the doctor and existing patient office visits or phone consults are 15-30 minutes. Due to the complexity of the injuries in each individual, we cannot guarantee a time frame for each office visit.

Patients that present with documentation of the accident, and have confirmed Personal Injury Protection on their policy will not have initial out of pocket expenses. Those that do not have confirmed coverage, will have a \$500 cap of services before care can continue, or financial arrangements can be made.

* New Patients seen within 48 hours of scheduling their initial exam MUST pre-pay for their visit.

* X-rays and laboratory tests, if needed, are performed outside of our office.

Referrals:

Our office has been built on friendly referrals. We appreciate you telling your family, friends, and coworkers about the services we offer, and the progress you make while helping you achieve your health and wellness goals. *As a way to say "Thank You" to our existing patients, a \$10.00 coupon will be credited to your account to be used on your next office visit when a New Patient cites you as their referral source.*

Payment:

Payment is due at the time of services rendered, unless PIP coverage has been determined. We accept cash, check, and credit cards (No American Express). We provide the 3rd party payer the information needed for payment.

I have read and understand the above information and I accept the policies of Synergy Chiropractic of Houston.

Signature _____ Date _____



DOCTOR-PATIENT INFORMED CONSENT

HEALTH AND WELLNESS

We want our patients to be informed about our goals and philosophies, and what to expect from The Hayden Institute in regards to how we work to achieve health and wellness for you and your family. It is our premise that nutrition, and a properly functioning nervous system are the building blocks of life. When these foundational aspects are balanced, it allows the body the opportunity to use its own naturally occurring recuperative abilities. With this in mind, we seek to restore health through a natural means without the use of drugs or surgery (If medication or surgery is warranted we advise the patient accordingly). We do this by balancing the nutritional needs and restoring optimal neurological communication through a variety of techniques. We believe by supplying our patients with the building blocks of life, we give their body the maximum opportunity to utilize its inherent recuperative powers. We do not claim to treat or cure any specific disease or condition. The doctors at **Synergy Chiropractic** provide a specialized, unique, non-duplicating health service and are licensed by the state of Texas in their special areas of practice.

ANALYSIS AND APPROACH

Your doctor will conduct a functional analysis for the express purpose of determining the nutritional, and/or neurological deficiencies that hinder you from optimal wellness. Through various Complementary and Alternative Medicine techniques, your doctor will identify any nutritional, neurological, or structural imbalances that are contributing to the symptoms that you are experiencing. The doctor will utilize the aforementioned safe, drug free and non-invasive techniques to help you achieve your **wellness goals**.

RESULTS

The purpose of our office visits is to promote natural health through the stabilization of the nutritional, neurological, and structural systems of your body. Due to the individuality of each patient, it is difficult to predict the healing time needed for your specific presentation. For most patients, a response is seen quickly, however, in some cases there is a more gradual change in their symptoms. Two or more similar conditions may respond differently to the same type of care and actual response time is unpredictable. Many medical difficulties have found significant benefit through the approach we use at **Synergy Chiropractic**. Our doctors will work with you to help you make an informed decision prior to being accepted as a patient in our office.

DIAGNOSIS

Although the doctors at **Synergy Chiropractic** are experts in the analysis of the nutritional, neurological, and structural aspects of the human body, they will not make a diagnosis outside of their scope of practice. Patients that require additional testing (MRI, XRAY, Blood Stool, etc) will be informed and have access to those reports at any time.

INFORMED CONSENT - OFFICE SERVICES

By signing this page the patient gives the doctor permission and authority to use Complementary and Alternative Medicine techniques to assist in the achievement the patient's desired level of wellness. It is the responsibility of the patient to make any diagnosed or observed deformities, injuries, illnesses, or other pathological conditions known to the doctor in order to receive the most optimal care.

INFORMED CONSENT - TESTIMONIALS AND RESEARCH

The patient also gives permission to utilize audio, video, and written information, according to HIPAA guidelines (no use of complete names, address, etc), for research, presentations, promotional material, and other office applications should the doctor deem the case appropriate. Promotional testimonials may be edited for print and online distribution if needed.

By signing below, I agree to all of the above statements.

Signature: _____ Date: _____

Synergy Chiropractic of Houston

5151 Katy Fwy, Ste 201

Houston, TX 77007

T: 832-786-8404 F: 346-204-4106

Patient Consent to Shared Information

I _____ request that you, the recipient of this notice, accommodate any request made by Synergy Chiropractic of Houston in regards to the sharing of, discussion of and / or duplicate of any information regarding my medical records. Such cooperation will ensure my ability to receive the most thorough and comprehensive care to foster an optimal outcome and prognosis.

Patient Signature

Date

I authorize Synergy Chiropractic of Houston to share, discuss and/ or duplicate any information regarding my medical records with health professional necessary for consulting on and / or active in treatment for care management. This would also include legal counsel, if I have retained any such counsel to represent me in relation to my health care needs.

Patient Signature

Date

Should any financially related party including, but not limited to, insurance companies, legal representation, third party insurance companies or any other party fail to fully compensate Synergy Chiropractic of Houston for serviced rendered to me, I accept full immediate responsibility for any account balances incurred by care rendered to myself or my dependents.

Patient Signature

Date

I also grant the privilege to Synergy Chiropractic of Houston to obtain like information from any practitioner that has previously, concurrently, and/ or may in the future treat me as a patient, to obtain any information on my care under another practitioner that could foster through case management.

Thank You,

Patient Signature

Date

For Office Use Only:

Patient Full Name:

SS#:

/ /

DOB:

/ /



PATIENT INFORMATION

PERSONAL INFORMATION

FULL NAME:		D.O.B: (MM/DD/YY)	
STREET ADDRESS:			
CITY, STATE ZIP:			
EMAIL:		RECEIVE OFFICE NEWSLETTER: Y N	
HOME PHONE:		CELL PHONE:	
AGE:	HEIGHT:	WEIGHT:	OCCUPATION:
MARITAL STATUS: M W S D		PREGNANT: Y N	
PREFERRED TO BE CALLED:			
BLOOD TYPE: A B AB O		REFERRED BY:	
EMERGENCY CONTACT INFORMATION:			

PRIMARY HEALTH CONCERNS

LIST YOUR HEALTH CONCERNS ACCORDING TO SEVERITY	RATE OF SEVERITY 1 = MINIMAL 10 = UNBEARABLE	WHEN DID IT BEGIN?	HAVE YOU EVER HAD THIS BEFORE?	% OF THE DAY THAT SYMPTOMS ARE PRESENT?	BETTER? WORSE? SAME?
1.)					
2.)					
3.)					
4.)					
5.)					

DIAGNOSTIC TESTS (PLEASE BRING ALL REPORTS WITH YOU, OR FAX TO 346-204-4106)

TYPE OF TEST (BLOOD WORK, XRAY, MRI, ETC)	DATE OF TEST	POSITIVE FINDINGS
1.)		
2.)		
3.)		
4.)		

RECEIVED A DIAGNOSIS FOR ANY CONDITION BY ANOTHER HEALTH CARE PROVIDER? Y N

IF YES, WHAT WAS THE DIAGNOSIS? _____

WHO PROVIDED THE DIAGNOSIS? _____

DAILY ACTIVITIES

PLEASE DESCRIBE IN DETAIL THE AFFECTS THAT THE HEALTH CONCERNS OR DIAGNOSIS HAVE ON YOUR DAILY LIFE: FOR EXAMPLE: WORK, PLEASURE, RECREATION, HOBBIES, SLEEPING, ETC.



ACCIDENTS, SURGERIES, HOSPITALIZATIONS, INJURIES, MAJOR SCARS

AREA OF BODY	DATE

OTHER HEALTH CARE PROVIDERS (Even if your concerns are unrelated to the doctor's specialty.)

NAME:	TYPE OF DOCTOR:
ADDRESS:	
REASON FOR CARE:	
DID IT HELP:	ARE YOU STILL SEEING THEM:
WHAT DID THEY DO:	

NAME:	TYPE OF DOCTOR:
ADDRESS:	
REASON FOR CARE:	
DID IT HELP:	ARE YOU STILL SEEING THEM:
WHAT DID THEY DO:	

FAMILY HEALTH HISTORY (You, Children, Parents, Grandparents, Siblings)

- | | | |
|--|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Emotional Distress | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Problems (not age related) | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Auto-Immune Disorder | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Pain/Discomfort |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hernia | <input type="checkbox"/> Suicidal Thoughts/Actions |
| <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Tremors/Shaking |
| <input type="checkbox"/> Childhood Diseases | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Neurologic Disorder | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis/Bone Density | <input type="checkbox"/> Other _____ |

HEALTH GOALS (What *YOU* wish to achieve by being a patient in our office)

I have read, and agree to, the provided "Policy" and "Informed Consent" pages. I consent to a professional and complete nutritional, neurological and structural physical examination, and subsequent rehabilitation office sessions. I understand the office procedures regarding payment at time of service.

Signature: _____ Date: _____

Parent/Guardian if minor: _____



MEDICATIONS AND SUPPLEMENTS

Please list ALL medications and supplements that you are taking, the reason you are taking them, and the person that prescribed them to you (including yourself). This includes over the counter, prescription, recreational, vitamins, herbs, etc.

MEDICATIONS	PRESCRIPTION?	WHO PRESCRIBED?	REASON
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		
	Y N		

SUPPLEMENTS	REASON

Patient Basic Information

Automobile Accident Description

<p>Personal Information:</p> <p>First Name: <input style="width:100%;" type="text"/></p> <p>Last Name: <input style="width:100%;" type="text"/></p> <p>Middle Initial: <input style="width:100%;" type="text"/></p>	<p>Your Vehicle Type:</p> <p><input type="radio"/> Car <input type="radio"/> S.U.V. <input type="radio"/> Van <input type="radio"/> Bus <input type="radio"/> Large Truck <input type="radio"/> Pickup Truck</p> <p>Other Type: _____</p>	<p>Your Position in Vehicle</p> <p><input type="radio"/> Driver <input type="radio"/> Front Passenger <input type="radio"/> L.Rear Passenger <input type="radio"/> R.Rear Passenger</p> <p>Other Position: _____</p>
<p>Address:</p> <p>City, State, Zip: <input style="width:100%;" type="text"/></p>	<p>Time/Speed/Damage</p> <p>Time of Accident: <input style="width:50%;" type="text"/> Your Speed <input style="width:50%;" type="text"/> Their Speed <input style="width:50%;" type="text"/></p>	<p>Damage to your vehicle:</p> <p><input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Totaled</p>
<p>Home Phone: <input style="width:50%;" type="text"/> Work Phone: <input style="width:50%;" type="text"/></p> <p>Social Security No: <input style="width:100%;" type="text"/></p> <p>Date of Birth: <input style="width:100%;" type="text"/></p> <p>Date of Injury/Onset: <input style="width:100%;" type="text"/></p>	<p>What was your vehicle doing at time of accident?</p> <p><input type="radio"/> Stopped at intersection <input type="radio"/> Stopped at intersection <input type="radio"/> Stopped at a light <input type="radio"/> Making a right turn <input type="radio"/> Stopped a left turn <input type="radio"/> Parking <input type="radio"/> Proceeding along <input type="radio"/> Slowing down <input type="radio"/> Accelerating</p> <p>Other: _____</p>	
<p>Dominant Hand: <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both</p>	<p>Details of Accident:</p>	
<p>Insurance Information:</p> <p>Policy Holder (if different than patient): <input style="width:100%;" type="text"/></p> <p>Policy No: <input style="width:50%;" type="text"/> Claim No: <input style="width:50%;" type="text"/></p>	<p>Point of Impact:</p> <p><input type="radio"/> Head-On <input type="radio"/> Rear-End <input type="radio"/> Left front <input type="radio"/> Right front <input type="radio"/> Left rear <input type="radio"/> Right rear</p>	<p>Who hit who/what:</p> <p><input type="radio"/> You hit other vehicle <input type="radio"/> Other vehicle hit you You hit...(Type in object below) Other: _____</p>
<p>Description of Accident/Injury/Onset</p> <p>If this is an automobile accident, you can use the MVA Section.</p>	<p>Additional Accident Information:</p> <p>In the case of a motor vehicle accident, write any additional info here.</p>	
<p>During and after accident details</p> <p>Enter details of your condition during and after the injury/onset.</p>	<p>During the Accident:</p> <p>Body Position, etc.</p> <p>Did you see the accident coming?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Were you braced for the impact?.....Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a seat belt on?.....Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a shoulder harness on? Yes <input type="checkbox"/> No <input type="checkbox"/> Did the driver's front air bag deploy?.. Yes <input type="checkbox"/> No <input type="checkbox"/> Did passenger front air bags deploy? Yes <input type="checkbox"/> No <input type="checkbox"/> Did the side air bags deploy?..... Yes <input type="checkbox"/> No <input type="checkbox"/> Does your vehicle have headrests?... Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Headrest Position?</p> <p><input type="radio"/> Even with top of head <input type="radio"/> Even with bottom of head <input type="radio"/> Even with middle of the neck</p>
<p>What was the direction of the head at the time of impact?</p> <p><input type="radio"/> Facing straight forward <input type="radio"/> Turned to the right <input type="radio"/> Turned to the left</p>		
<p>Did your body strike the inside of your vehicle?.....Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, describe: <input style="width:100%;" type="text"/></p> <p>Did you lose consciousness during the injury?.....Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, for how long? <input style="width:100%;" type="text"/></p> <p>Your vehicle's Estimated Damage: <input style="width:50%;" type="text"/> Damage to their vehicle: <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Totaled</p>		
<p>Did police show up at the scene? Yes <input type="checkbox"/> No <input type="checkbox"/> Was an accident report filled out? Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>Emergency Room?</p> <p>Where did you go after the accident?</p> <p><input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Hospital ER <input type="radio"/> Private doctor</p> <p>How did you get there?</p> <p><input type="radio"/> Drove Self <input type="radio"/> Ambulance <input type="radio"/> Somebody Else <input type="radio"/> Police</p>		
<p>X-rays done? Yes <input type="checkbox"/> No <input type="checkbox"/> Was lab work done? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Body parts X-rayed? <input style="width:50%;" type="text"/> What lab work? <input style="width:50%;" type="text"/></p> <p>The x-rays revealed.. <input style="width:100%;" type="text"/></p> <p>Treatments: <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Ice Other <input style="width:50%;" type="text"/></p> <p>Medications: <input style="width:100%;" type="text"/></p> <p>Follow-up Instructions: <input style="width:100%;" type="text"/></p>		
<p>After the Accident:</p> <p>Check off the symptoms right after and a few days following the accident.</p> <p><input type="checkbox"/> Headache <input type="checkbox"/> Loss of smell <input type="checkbox"/> Tension <input type="checkbox"/> Loss of taste <input type="checkbox"/> Diarrhea <input type="checkbox"/> Neck pain <input type="checkbox"/> Dizziness <input type="checkbox"/> Irritability <input type="checkbox"/> Toe numbness <input type="checkbox"/> Depression <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Nausea <input type="checkbox"/> Mid back pain <input type="checkbox"/> Constipation <input type="checkbox"/> Anxious <input type="checkbox"/> Fainting <input type="checkbox"/> Confusion <input type="checkbox"/> Low back pain <input type="checkbox"/> Cold hands <input type="checkbox"/> Chest pain <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Fatigue <input type="checkbox"/> Nervousness <input type="checkbox"/> Cold Feet <input type="checkbox"/> Pain behind eyes <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleeping problems</p> <p>Others: <input style="width:100%;" type="text"/></p>		
<p>Doctor's Additional Data on This Patient</p> <p>NOTE: This will be entered into the chart, but will not appear in Reports</p>		

Patient's Signature: _____ **Date:** _____

Historical Information

Prior Treatment Information

Prior Similar Symptoms: <input type="radio"/> I have NOT had prior similar symptoms to current complaints. <input type="radio"/> My current complaints DID exist before, but had been dormant. <input type="radio"/> My current complaints ALREADY existed and were worsened.		Has your History Contributed to your Symptoms? <input type="radio"/> My history HAS contributed to my current symptoms. <input type="radio"/> My history HAS NOT contributed to my current symptoms. <input type="radio"/> I'm NOT SURE if my history has contributed to my symptoms.		My Most Recent Prior Similar Symptoms (if applicable) My most recent prior similar symptoms occurred... <input type="checkbox"/> Months <input type="checkbox"/> Years...ago OR on (Date) <input type="text"/>																					
Medical History Section: Enter additional Medical Historical data here.	Surgical Historical Section: Enter any Surgical Historical data here.	Treatment History 1: Fill in any other doctor(s) seen prior to your first visit to this office. <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">2. Name: <input type="text"/></td> <td style="width: 20%;">Specialty: <input type="text"/></td> <td style="width: 10%; text-align: right;">First Visit Date</td> <td style="width: 10%;"><input type="text"/></td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;">Last Visit Date</td> </tr> <tr> <td colspan="3">Types of Treatments Received: <input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>How many Tx's Received?</td> <td>Did Tx's help?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>X-rays done?</td> </tr> <tr> <td><input type="text"/></td> <td>Currently Treating?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>				2. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>				Last Visit Date	Types of Treatments Received: <input type="text"/>			<input type="text"/>	How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?	<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>																						
			Last Visit Date																						
Types of Treatments Received: <input type="text"/>			<input type="text"/>																						
How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?																						
<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>																						
Medications History Section: Enter any Medications Historical data here.	Occupational History Section: Enter Occupational History, e.g. lost work, etc. Here.	Treatment History 2: Fill in any other doctor(s) seen prior to your first visit to this office. <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">2. Name: <input type="text"/></td> <td style="width: 20%;">Specialty: <input type="text"/></td> <td style="width: 10%; text-align: right;">First Visit Date</td> <td style="width: 10%;"><input type="text"/></td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;">Last Visit Date</td> </tr> <tr> <td colspan="3">Types of Treatments Received: <input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>How many Tx's Received?</td> <td>Did Tx's help?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>X-rays done?</td> </tr> <tr> <td><input type="text"/></td> <td>Currently Treating?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>				2. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>				Last Visit Date	Types of Treatments Received: <input type="text"/>			<input type="text"/>	How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?	<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>																						
			Last Visit Date																						
Types of Treatments Received: <input type="text"/>			<input type="text"/>																						
How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?																						
<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>																						
Familial History Section: Enter relevant Familial History here.	Social History Section: Enter any relevant Social History here.	Treatment History 3: Fill in any other doctor(s) seen prior to your first visit to this office. <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">1. Name: <input type="text"/></td> <td style="width: 20%;">Specialty: <input type="text"/></td> <td style="width: 10%; text-align: right;">First Visit Date</td> <td style="width: 10%;"><input type="text"/></td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;">Last Visit Date</td> </tr> <tr> <td colspan="3">Types of Treatments Received: <input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>How many Tx's Received?</td> <td>Did Tx's help?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>X-rays done?</td> </tr> <tr> <td><input type="text"/></td> <td>Currently Treating?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>				1. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>				Last Visit Date	Types of Treatments Received: <input type="text"/>			<input type="text"/>	How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?	<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
1. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>																						
			Last Visit Date																						
Types of Treatments Received: <input type="text"/>			<input type="text"/>																						
How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?																						
<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>																						
Additional Historical Information Section: Summarize other treatments that were received here.	Prior Treatment Section: Summarize past treatments received here.	Treatment History 4: Fill in any other doctor(s) seen prior to your first visit to this office. <table border="0" style="width: 100%;"> <tr> <td style="width: 60%;">4. Name: <input type="text"/></td> <td style="width: 20%;">Specialty: <input type="text"/></td> <td style="width: 10%; text-align: right;">First Visit Date</td> <td style="width: 10%;"><input type="text"/></td> </tr> <tr> <td colspan="3"></td> <td style="text-align: right;">Last Visit Date</td> </tr> <tr> <td colspan="3">Types of Treatments Received: <input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>How many Tx's Received?</td> <td>Did Tx's help?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>X-rays done?</td> </tr> <tr> <td><input type="text"/></td> <td>Currently Treating?</td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> </tr> </table>				4. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>				Last Visit Date	Types of Treatments Received: <input type="text"/>			<input type="text"/>	How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?	<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Name: <input type="text"/>	Specialty: <input type="text"/>	First Visit Date	<input type="text"/>																						
			Last Visit Date																						
Types of Treatments Received: <input type="text"/>			<input type="text"/>																						
How many Tx's Received?	Did Tx's help?	Yes <input type="checkbox"/> No <input type="checkbox"/>	X-rays done?																						
<input type="text"/>	Currently Treating?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>																						

Patient's Signature: _____ Date: _____

Back Pain Index (Oswestry)

Total Score: _____

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally but it is very painful. (0)
- It is painful to look after myself and I am slow and careful. (1)
- I need some help but manage most of my personal care. (2)
- I need help every day in most aspects of my personal care. (3)
- I need help every day in most aspects of self-care. (4)
- I do not get dressed, wash with difficulty, and stay in bed. (5)

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table). (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift only very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Walking

- Pain does not prevent me walking any distance. (0)
- Pain prevents me walking more than 1 mile. (1)
- Pain prevents me walking more than ¼ of a mile. (2)
- Pain prevents me walking more than 100 yards. (3)
- I can only walk using a stick or crutches. (4)
- I am in bed most of the time and have to crawl to the toilet. (5)

Section 5 – Sitting

- I can sit in any chair as long as I like. (0)
- I can sit in my favorite chair as long as I like. (1)
- Pain prevents me from sitting for more than 1 hour. (2)
- Pain prevents me from sitting for more than ½ hour. (3)
- Pain prevents me from sitting for more than 10 minutes. (4)
- Pain prevents me from sitting at all. (5)

Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- My sleep is never disturbed by pain. (0)
- My sleep is occasionally disturbed by pain. (1)
- Because of pain, I have less than 6 hours sleep. (2)
- Because of pain, I have less than 4 hours sleep. (3)
- Because of pain, I have less than 2 hours sleep. (4)
- Pain prevents me from sleeping at all. (5)

Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain. (0)
- My sex life is normal but causes some extra pain. (1)
- My sex life is nearly normal but is very painful. (2)
- My sex life is severely restricted by pain. (3)
- My sex life is nearly absent because of pain. (4)
- Pain prevents any sex life at all. (5)

Section 9 – Social Life

- My social life is normal and cause me no extra pain. (0)
- My social life is normal but increases the degree of pain. (1)
- Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. sports). (2)
- Pain has restricted my social life and I do not go out as often. (3)
- Pain has restricted social life to my home. (4)
- I have no social life because of pain. (5)

Section 10 – Traveling

- I can travel anywhere without pain. (0)
- I can travel anywhere but it gives extra pain. (1)
- Pain is bad but I manage journeys of over two hours. (2)
- Pain restricts me to short necessary journeys under 30 minutes. (3)
- Pain prevents me from traveling except to receive treatment. (4)
- I cannot travel at all. (5)

Section 11 – Previous Treatment

Over the past three months have you received treatment, tablets or medicines of any kind for your back or leg pain? Please check the appropriate box.

- No Yes (if yes, please state the type of treatment you have received)

Neck Pain Index

Total Score: _____

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment. (0)
- The pain is very mild at the moment. (1)
- The pain is moderate at the moment. (2)
- The pain is fairly severe at the moment. (3)
- The pain is very severe at the moment. (4)
- The pain is the worst imaginable at the moment. (5)

Section 2 – Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain. (0)
- I can look after myself normally but it causes extra pain. (1)
- It is painful to look after myself and I am slow and careful. (2)
- I need some help but manage most of my personal care. (3)
- I need help every day in most aspects of self care. (4)
- I do not get dressed, I wash with difficulty and stay in bed. (5)

Section 3 – Lifting

- I can lift heavy weights without extra pain. (0)
- I can lift heavy weights but it gives extra pain. (1)
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. (2)
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. (3)
- I can lift very light weights. (4)
- I cannot lift or carry anything at all. (5)

Section 4 – Reading

- I can read as much as I want to with no pain in my neck. (0)
- I can read as much as I want to with slight pain in my neck. (1)
- I can read as much as I want with moderate pain in my neck. (2)
- I cannot read as much as I want because of moderate pain in my neck. (3)
- I can hardly read at all because of severe pain in my neck. (4)
- I cannot read at all. (5)

Section 5 – Headaches

- I have no headaches at all. (0)
- I have slight headaches that come infrequently. (1)
- I have moderate headaches which come infrequently. (2)
- I have moderate headaches which come frequently. (3)
- I have severe headaches which come frequently. (4)
- I have headaches almost all the time. (5)

Section 6 – Concentration

- I can concentrate fully when I want to with no difficulty. (0)
- I can concentrate fully when I want to with slight difficulty. (1)
- I have a fair degree of difficulty in concentrating when I want to. (2)
- I have a lot of difficulty in concentrating when I want to. (3)
- I have a great deal of difficulty in concentrating when I want to. (4)
- I cannot concentrate at all. (5)

Section 7 – Work

- I can do as much work as I want to. (0)
- I can do my usual work, but no more. (1)
- I can do most of my usual work, but no more. (2)
- I cannot do my usual work. (3)
- I can hardly do any work at all. (4)
- I cannot do any work at all. (5)

Section 8 – Driving

- I can drive my car without any neck pain. (0)
- I can drive my car as long as I want with slight pain in my neck. (1)
- I can drive my car as long as I want with moderate pain in my neck. (2)
- I cannot drive my car as long as I want because of moderate pain in my neck. (3)
- I can hardly drive at all because of severe pain in my neck. (4)
- I cannot drive my car at all. (5)

Section 9 – Sleeping

- I have no trouble sleeping. (0)
- My sleep is slightly disturbed (less than 1 hour sleepless). (1)
- My sleep is mildly disturbed (1-2 hours sleepless). (2)
- My sleep is moderately disturbed (2-3 hours sleepless). (3)
- My sleep is greatly disturbed (3-5 hours sleepless). (4)
- My sleep is completely disturbed (5-7 hours sleepless). (5)

Section 10 – Recreation

- I am able to engage in all my recreation activities with no neck pain at all. (0)
- I am able to engage in all my recreation activities, with some pain in my neck. (1)
- I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. (2)
- I am able to engage in a few of my usual recreation activities because of pain in my neck. (3)
- I can hardly do any recreation activities because of pain in my neck. (4)
- I cannot do any recreation activities at all. (5)

Legal Assignment of Benefits and Release of Medical and Plan Documents

Medical group name: **Synergy Chiropractic of Houston, PLLC**

Are your present symptoms or conditions related to or, the result of any auto accident, work-related injury or other personal injury for which someone else might be legally liable? Yes No Your initials: _____

Responsible party (Insurance Company, Attorney, etc): _____

Contact Person: _____ Phone number: _____

Fax: _____ Address: _____ City, State, Zip: _____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the above captioned. I hereby assign and convey directly to the medical group all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such medical group. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the medical group to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such medical group any and all plan documents, insurance policy and/or settlement information upon written request from such medical group in order to claim such medical benefits, reimbursement or any applicable remedies. I authorized the use of this signature on all my insurance and/or employee health benefits claim submissions.

Medical Group may bill my insurance on my behalf. Although Medical Group may have verified benefits for the patient, the verification is not a guarantee of benefits and ultimate coverage and payment lies in the sole discretion of the insurance company based on policy guidelines. Ultimately, the Patient/Beneficiary is responsible for the charges, except contrary to federal or state law and will pursue any disputes with my insurance company, self-insured employer or other third party payor to enable proper health coverage benefits to be paid. I hereby authorize the above named physician and/or its affiliates to appeal claims under Employee Retirement Income Security Act (ERISA) and/or state laws with applicable as situations occur.

I hereby convey to the above named medical group to the full extent permissible under the law and under any applicable insurance policies and/or employee healthcare plan any claim, choose in action, or other right I any have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named medical group and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such medical group in any attempts by such medical group to pursue such claim, choose in action or right against my insurers and/or employee healthcare plan, including, if necessary, bring suit with such medical group against such insurers and/or employee healthcare plan in my name but at such medical group's expense.

I, the Patient/Beneficiary, hereby authorize medical group to release to my attorney, my insurance provider, my worker's compensation provider, or my referring physician any and all medical information pertinent to medical services provided by medical group.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provisions within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and do fully understand this agreement.

INSURANCE PAYMENT INFORMATION

As medical group may not be a plan provider for your insurance provider, please be advised that your insurance provider may forward payment or payment information directly to you the Patient/Beneficiary.

When written communication from your insurance regarding medical services provided by medical group is received, I, the undersigned insured, promise to send a copy to medical group immediately.

In the event a benefits check for medical services provided by medical group is received, I promise to endorse the check immediately and forward to medical group by certified mail, or to send a personal check within 48 hours for the value of the benefits check. In the event I send a personal check, I promise to also send a copy of the explanation of benefits from my insurance carrier, explaining the payment received by me.

I, the Patient/Beneficiary, understand that failure to reimburse medical group for insurance benefits received for medical services rendered will cause the full open balance of all charges to become due and payable immediately, and that I will be responsible for legal or collection fees if incurred.

Medical group is willing to await your payment from your insurance carrier before requiring your direct payment by you to us for the medical services, and ordered by your physician.

Signature of Responsible Party/Guardian: _____ Date: _____