Thank you for choosing Synaptic Chiropractic Center.

We know…it looks like there is a lot of paper work, but don't worry, many of the pages may not need to be completed unless you have multiple symptoms and several pages only require your signature. We do not like paperwork anymore than you do…this is the absolute minimum that we are required to collect prior to your 1st office visit. This should take about 10 minutes to complete.

For your convenience our intake forms are attached below. Please complete the attached forms and bring them to your initial appointment. Please also be sure to **bring** your **health insurance** card and **drivers license.**

Health Insurance: The following information is necessary to submit claims to your insurance company. As a convenience to you we will submit all of your insurance claims and also verify your Chiropractic benefits. **It is important for you to understand that your insurance is a contract between you and your chosen insurance carrier, and we cannot change or modify your plan.** You should take care to familiarize yourself with your individual benefits.

Health Insurance FACT:
Many Health Insurance contracts may not cover enough treatments to allow for a full recovery of your condition. You may need additional treatments that your insurance will not cover. Please ask the front desk staff if you have any questions.

Payment or Co-payment: is expected at your office visit. For your convenience we also accept Checks, Cash, MasterCard and Visa.

Insurance Referral: If your insurance requires a referral from your primary care physician or a prior authorization from your insurance company, this should be obtained prior to your visit. Please have your medical doctor fax this referral to our office at (978) 939-8786.

Thank you for your cooperation and if you have any questions, please do not hesitate to ask.

Patient Health and Illness History

Name_____ **Social Security Number** _____-_____-_____
(first name) (last name)

Address_____
(Street) (City) (State) (Zip)

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

Mobile Phone (_____) _____ **Email** _____

Date of Birth ____/_____/_____ **Age**____ **Sex M or F**

Marital Status: S M D W

Occupation_____**Employer**_____**Years Employed**____

Address_____ _____
(Street) (City) (State) (Zip)

Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Insurance Information

Primary Insurance Co. _____ **Policy #** _____
Address _____**Phone # (_____)** _____

Secondary/Other Insurance Co. _____**Policy #** _____
Address _____ **Phone # (_____)** _____

Relationship to Insured ____ **Self** ____ **Spouse** ____ **Child** _____**Other**

If other, please specify _____

Other Insured's Name_____

Other Insured's Date of Birth ____/_____/_____

Other Insured's Employer's Name _____

How did you hear about us?

Were you referred to our Clinic? If yes, by whom_____

How did you hear about Synaptic? ___Ad __Phone Book ___Brochure ___Sign
___Health Talk Other? _____

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

I understand and agree that health and accident insurance policies are an agreement between me and my insurance carrier. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I understand and agree that all services not covered by my insurance become my personal responsibility for payment. I understand that if I suspend or terminate my care and treatment, all outstanding monies will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient Signature _____ Date _____

CHIEF COMPLAINTS

1. Did your symptoms start all of a sudden or gradually? **Suddenly** **Gradually**

2. Please explain (if known) what caused your symptoms:_____
_____

3. Is your injury related to work? **Y** **N**
If YES, date of injury ___/___/____

Did you file an injury report with your employer? **Y** **N**

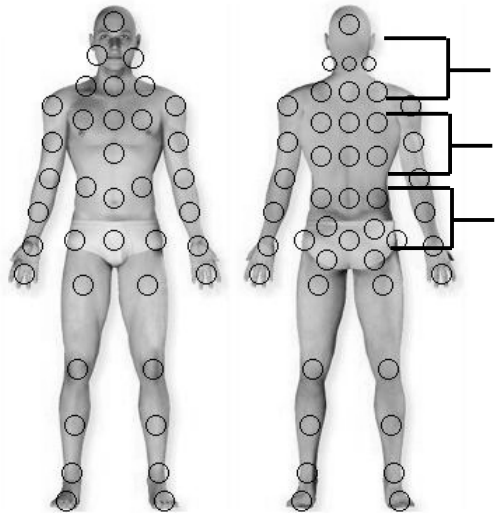
4. Is your injury related to an automobile accident? **Y** **N**
If YES, date of accident ___/___/____

Was a police report filed? **Y** **N**
If YES, in what city and state?:_____

5. Where is your PRIMARY complaint located?
Please mark on the diagram below where you would like your treatment to be focused.

Please choose 1 region as your primary area of discomfort and show on the diagram:

- ☐ **Neck**
- ☐ **Mid-Back**
- ☐ **Low-Back/Hips**



6. How long have your symptoms been present?

- ☐ **For an unspecified period of time**
- ☐ **Since waking up**
- ☐ **For the last few hours**
- ☐ **All day**
- ☐ **For the past two days**
- ☐ **For the past three days**
- ☐ **For the past several days**
- ☐ **For the past week**
- ☐ **For the past few weeks**
- ☐ **For the past month**
- ☐ **For the past several months**
- ☐ **For the past year**
- ☐ **For the past several years**
- ☐ **Other:**_____

7. What type of discomfort are you feeling? Please select all that apply:

- ☐ **Aching**
- ☐ **Burning**
- ☐ **Dull**
- ☐ **Numbness**
- ☐ **Painful**
- ☐ **Pinching**
- ☐ **Sharp**
- ☐ **Shooting**
- ☐ **Throbbing**
- ☐ **Tightness**
- ☐ **Tingling**
- ☐ **Other:**_____

8. What is the daily frequency of your symptoms?

- ☐ Occasional (0-25%)
- ☐ Intermittent (26-50%)
- ☐ Frequent (51-75%)
- ☐ Continuous (76-100%)

9. Which of the following activities <u>AGGRAVATES</u> your symptoms? Please select all that apply:

- ☐ None
- ☐ Almost any movement
- ☐ Bending
- ☐ Carrying
- ☐ Carrying groceries
- ☐ Cleaning
- ☐ Climbing stairs
- ☐ Coughing and Sneezing
- ☐ Cutting wood
- ☐ Daily child care
- ☐ Driving
- ☐ Exercising
- ☐ Extended computer use
- ☐ Gardening
- ☐ Getting out of bed
- ☐ Getting dressed
- ☐ Getting up from lying or sitting
- ☐ Going to the bathroom
- ☐ Golfing
- ☐ Having sex
- ☐ Household chores
- ☐ Kneeling
- ☐ Lifting
- ☐ Lying down
- ☐ Playing Sports
- ☐ Raking
- ☐ Reaching
- ☐ Repetative motions
- ☐ Resting
- ☐ Running
- ☐ Shoveling
- ☐ Sitting
- ☐ Sitting to standing
- ☐ Sitting for extended periods of time
- ☐ Sleeping
- ☐ Standing
- ☐ Squating
- ☐ Stress
- ☐ Turning
- ☐ Twisting
- ☐ Typing
- ☐ Walking
- ☐ Walking down/up stairs
- ☐ Weight-lifting
- ☐ Working
- ☐ Yard work
- ☐ Other:_____ _____

10. Which of the following <u>HELPS</u> your symptoms? Please select all that apply:

- ☐ Nothing
- ☐ Changing positions
- ☐ Chiropractic adjustments
- ☐ Ice
- ☐ Exercising
- ☐ Heat
- ☐ Hot shower
- ☐ Lying down
- ☐ Massage
- ☐ Medication (specify) _____ _____ _____
- ☐ Resting
- ☐ Sitting
- ☐ Sleeping
- ☐ Stretching
- ☐ Walking
- ☐ Other:_____ _____

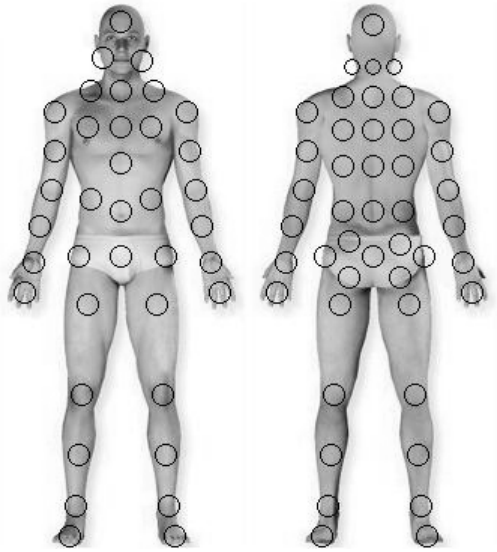
11.On a scale of 0 to 10 with 10 being the worst, please rate your pain: 1 2 3 4 5 6 7 8 9 10

12. What percent of the day do you notice your pain? 0% 5% 10% 20% 25% 30% 40% 50% 60% 70% 75% 80% 90% 100%

13. When are your symptoms most noticeable?

- ☐ In the morning
- ☐ During the day
- ☐ In the mid day
- ☐ In the afternoon
- ☐ In the late afternoon
- ☐ In the evening
- ☐ While trying to sleep
- ☐ When going from seated to standing
- ☐ When going from laying to upright
- ☐ While working
- ☐ While driving
- ☐ At non-specific time frame

14. Do you have any ⊗Pain ●Numbness ★Tingling ▲Burning in your arms or legs? Y N
If YES, please indicate where on the diagram below <u>using the symbols shown above</u>.



<u>RED FLAGS</u>

15. Does your pain wake you up at night? Y N
****<u>NOTE</u>: Difficulty sleeping due to the pain is NOT the same as the pain waking you up from sleep.****

16. Do any of the following apply to you?
- ☐ **Usage of (blood thinners) anticoagulant medication**
- ☐ **Severe, unrelenting pain**
- ☐ **Pain not releived by rest**
- ☐ **Recent spinal surgery**
- ☐ **Recent spinal trauma**
- ☐ **None of the above**

<u>PATIENT GOALS</u>

17. What are your short term goals of care? Please select all that apply:
- ☐ **Decrease pain**
- ☐ **Improve core stability**
- ☐ **Improve nutrition**
- ☐ **Improve overall health and wellness**
- ☐ **Improve pain management**
- ☐ **Improve range of motion**
- ☐ **Increase the ability to perform daily activities**
- ☐ **Lose weight**
- ☐ **Preventative care**
- ☐ **Relief of symptoms**
- ☐ **Return to preinjury status**
- ☐ **Slow spinal degeneration**
- ☐ **Surgical avoidance**
- ☐ **Wellness care**

GENERAL HEALTH

Please fill in this section to the best of your ability

Height: _____ Weight:_____ Blood Pressure (if known):_____ /_____

1. Have you ever had any problems with any of the following? (Describe where appropriate)

A. General: **Y N __normal __fatigue __weakness __fever __loss of sleep __chills __weight changes __night sweats**

B. Neurologic **Y N __headache __dizziness __fainting __convulsions __nervousness __ other: _____**

C. Eyes **Y N**_____

D. Ears **Y N**_____

E. Nose **Y N**_____

F. Mouth/Throat **Y N**_____

G. Skin **Y N**_____

H. Heart/Lungs **Y N**_____

I. High BP/Stroke **Y N**_____

J. Breasts **Y N**_____

K. Genitourinary **Y N Bladder Prostate Hormone Therapy Other:**_____

L. Endocrine **Y N Diabetes Thyroid Other:** _____

M. Psychological **Y N**_____

N. Cancer **Y N**_____

O. Digestive Issues **Y N**_____

****Women ONLY****

- ♀ **Are you or could you be pregnant? Y N**
- ♀ **Have past pregnancies been normal? Y N**
- ♀ **Are you seeing an OB-GYN regularly? Y N**
- ♀ **Date of last exam: _____**

PAST MEDICAL HISTORY

1. **Have you been to a chiropractor before? Y N**
   If YES, Who? _____ When? _____
2. **Do you have a Family Physician? Y N**
   If YES, Who? _____
   - **Address: _____**
   - **Phone #: _____**
3. **When was your last physical exam? ____/____/_____**
4. **Do you have any images (i.e., X-Ray, MRI, CT-Scan) of your spine or area of complaint? Y N**

   If YES, what imaging was performed, where (ex., Heywood Hospital), and when?
   - **X-Ray >>>>Body area: Where: Date:**
   - **MRI >>>>>Body area: Where: Date:**
   - **CT >>>>>>Body area: Where: Date:**
   - **Other >>>>Body area: Where: Date:**
5. **Have you been hospitalized in the last 5 years? Y N If YES, please explain?**
   _____
6. **Have you had surgery in the last 5 years? Y N If YES, please explain?**
   _____
7. **Please list any medications you are currently taking, if none please indicate NONE:**
   (You may attach a separate sheet of paper if needed)

   _____ _____
   _____ _____
   _____ _____
   _____ _____
   _____ _____
8. **Please list any vitamins or supplements you are currently taking:**

   _____
   _____
   _____
   _____

   Would you like the doctor to make any recommendations regarding Nutritional Supplements?

   Y N
9. **Do you have any medication allergies?**

   _____ _____
   _____ _____
   _____ _____

FAMILY HEALTH AND ILLNESS HISTORY

Please tell us if YOU are living with any of the following major health problems:

Cancer: Y N **Diabetes:** Y N

If YES, please specify>>_____ **If YES, please specify >>>** ***Type I*** ***Type II***

Heart Disease: Y N **Stroke:** Y N

High Blood Pressure: Y N **Arthritis:** Y N

If YES, please specify>>> ***Osteo*** ***Rheumatoid***

Previous Spinal Diagnosis: _____ **Other: _____**

Please tell us if anyone in your immediate family is living with any of the major health problems mentioned above:

Mother **Alive** **Health Problems_____**

Deceased **Age_____ Cause of Death_____**

Father **Alive** **Health Problems_____**

Deceased **Age_____ Cause of Death_____**

Sibling **Alive** **Health Problems_____**

Deceased **Age_____ Cause of Death_____**

Sibling **Alive** **Health Problems_____**

Deceased **Age_____ Cause of Death_____**

Sibling **Alive** **Health Problems_____**

Deceased **Age_____ Cause of Death_____**

Authorization to Release Medical Records

I, _____ authorize Dr. Todd Mexico, D.C. and Synaptic Chiropractic Center to release my records from Synaptic to _____, my Family Physician as well as to _____, the Specialist that I have seen for my condition *(if applicable)*.

_____	_____	_____
Patient Name	Patient/Guardian Signature	Date

Authorization for Release of Medical Information

I _____request and authorize_____ to release ANY **DIAGNOSTIC IMAGING REPORTS OF THE SPINE ONLY** to Synaptic Chiropractic Center to help them in determining my care.

Please Fax Records to: Dr. Todd Mexico, D.C.

Fax Number: (978) 939-8786

Patient Signature: _____ Date of Birth: _____

Social Security Number: _____

Informed Consent to Care at Synaptic Chiropractic Center

Please read carefully and initial in the box by each statement.

☐ I agree and understand that it is not uncommon that patients can have some increased discomfort after an adjustment. If this happens to me, I can apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the clinic and ask questions. If I am out of town or are unable to contact the doctor, I can present myself to the emergency room.

☐ I agree and understand that if any tests are performed outside of this office (lab tests or other diagnostic procedures) I understand that the doctor will notify me of the results on my next scheduled appointment.

☐ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic.

☐ I agree and understand that the results of chiropractic care are not guaranteed and I may ask the doctor of chiropractic the purpose of chiropractic adjustments and procedures done in this clinic.

☐ I agree and understand and am now informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

☐ I have read the above consent and it is indicated by my initials next to each statement and by doing so I agree to the above named procedures. I understand and agree that I do not have to sign this consent prior to speaking with the doctor if I have any questions or concerns, however I know this consent must be signed prior to beginning care. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____ _____

Patient Name Patient/Guardian Signature Date

Dr. Todd Mexico, D.C. is the Chiropractic Physician at this office.

Missed Appointment Policy

There is a $45.00 charge for missed appointments without a 24-hour notice. This charge is the patient's responsibility and cannot be billed to the insurance company. Missed appointment fees must be paid before scheduling subsequent appointments.

Attending your appointments will maximize your likeliness of recovery. If you miss appointments the doctor cannot help you recover. If multiple appointments are missed without notification, we may recommend that you seek treatment at another facility.

Signature: _____ Date: _____