New Patient Application Form

Dear Friend,

Congratulations on taking this very important step towards improving your health potential. We are honored and excited to have the opportunity to see if our unique approach can help you. The Synergy Oviedo Chiropractic concept offers you more…

Synergy Oviedo Chiropractic offers a collaboration of multiple healing arts that produces a greater level of health than the sum of the individual healing approaches. Synergy creates amazing individual health which in turn impacts the whole family allowing them to achieve their goals with joy, love, and enthusiasm.

The following information will help discover your specific needs and allow us to fully address the root cause of your condition. We work as a team, using many different healing arts (Chiropractic, Medicine, Massage, Physical Therapy), to help you add life to all of your years.

Our New Patient process typically takes two visits. Your first visit allows us to thoroughly listen to your needs and concerns and carefully evaluate your spine and nervous system. We offer on site state of the art digital x-ray technology. Your follow up consultation will be one of the most important visits you have at Synergy Oviedo Chiropractic as we will outline for you and your family your results and recommended action plan. You may also begin your care here on your second visit.

We value you and your desire to gain optimal health. We promise to take the time to listen to you and make this experience an enjoyable one. Please call today at (407) 505-4320 if you have any questions.

Welcome to our Synergy Family,
Dr. Eric Janowitz and Team Synergy

^#DATE#^

New Patient Application

Title: Mr. Mrs. Ms. Dr.

Last Name: ______________________________ First Name: _____________________ MI: ________

Nick Name: _____________ Date of Birth: ____/____/____ SS #: _____-___-____ Marital Status: ____

Home Address: ____ Apt#: ____________

City: ___________________ State:_________ Zip: _________ Home Phone: (____) ______________

Cell Phone: (____) ______________________ E-Mail____

Work Phone: (____) __________________ May we contact you at work? ☐ Yes ☐ No

Employer Name: _______________________________________ Occupation:____________________

Insurance Co: __________________________ Group ID#:_________ Ins ID #: _____________________

Name of Insured: ____________________________________ Insured's Date of Birth: ____/____/____

Spouse Name: ______________________________________ Occupation:______________________

Financially responsible person if other than patient:

Last Name: ______________________________ First Name: _______________ MI: _______________

Address: ____

City: _____________________ State: ________ Zip: ________________ Phone: (____) ___________

Date of Birth: _____/_____/_____ SS#: ____-___-_____ Relationship to Patient: __________________

Employer Name: _____________________________________ Employer Phone: (____) ____________

Emergency contact

Last Name: ______________________________ First Name: ____________________________

Contact Phone: (____) ______________________ Relation to patient:_______________________

Referral Source:

Who may we thank for referring you to our office? ____

Or, where did you hear about our office? ____

^#DATE#^

Current Health History: Spinal Subluxation (or misalignment) can cause your body to experience pain or other symptoms. The following questions will help the doctors better determine what may be causing your specific symptoms.
Chief complaint or reason for today's visit? ____

Is the condition related to Work ( ) Auto ( ) Date of Accident: _______________ Have you lost days from work? ______

What doctors have seen you for this current condition? ____

What did they do? ____

Name of last Chiropractor? ________________________ Date of last visit: __________ Were you helped? ___________

How long were you under care for this current episode? ________________ How were the results?______________________

What spinal correction programs were you given? ____

Did you follow them? ____________ If not, why? _______________________How did the post x-rays look? _________

To better serve you, please fill out the information below for each distinct problem area:

Current Problem #1

The pain is located ____

The pain started ______ ☐ days ago _______ ☐ weeks ago ________ ☐ months ago _________ ☐ years ago

On a scale of 1 (mild) -10 (severe) rate your pain 0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain ☐ dull, achy ☐ sharp, stabbing ☐ burning ☐ pins and needles

The pain is made *better* by ____

The pain is made *worse* by ____

The pain is worse in the __early am __mid day __late pm and occurs __constantly __on and off throughout the day or ___week

☐There is radiating pain, tingling, or numbness into ____

Activities Affected: ____

Additional Current Area #2

The pain is located ____

The pain started ______ ☐ days ago _______ ☐ weeks ago ________ ☐ months ago _________ ☐ years ago

On a scale of 1 (mild) -10 (severe) rate your pain 0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain ☐ dull, achy ☐ sharp, stabbing ☐ burning ☐ pins and needles

The pain is made *better* by ____

The pain is made *worse* by ____

The pain is worse in the __early am __mid day __late pm and occurs __constantly __on and off throughout the day or ___week

☐There is radiating pain, tingling, or numbness into ____

Activities Affected: ____

Additional Current Area #3

The pain is located ____

The pain started ______ ☐ days ago _______ ☐ weeks ago ________ ☐ months ago _________ ☐ years ago

On a scale of 1 (mild) -10 (severe) rate your pain 0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain ☐ dull, achy ☐ sharp, stabbing ☐ burning ☐ pins and needles

The pain is made *better* by ____

The pain is made *worse* by ____

The pain is worse in the __early am __mid day __late pm and occurs __constantly __on and off throughout the day or ___week

☐There is radiating pain, tingling, or numbness into ____

Activities Affected: ____

PAIN DISABILITY QUESTIONNAIRE

Patient Name ____ Date ^#DATE#^_______________

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with all my personal care
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

4. Does your pain affect your ability to sit or stand?
No problems — Can not sit/stand at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Can not do at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

7. Does your pain affect your ability to walk or run?
No problems — Can not walk/run at all
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

10. Does your pain force your to see doctors much more often than before your pain began?
Never see doctors — See doctors weekly
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
Never need help — Need help all the time
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
No problems — Severe problems
0 -------- 1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10

____
Examiner

OTHER COMMENTS:

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302.

^#DATE#^

Past History of Current Complaint

Have you suffered from a similar problem in the past? □ yes □ no If yes, how many times? ______________________

When was the last episode? _________________

When did the problems begin?

Identify any other injury/injuries to your spine, minor or major, that the doctor should know about. Please include any injuries that occurred as a child.

Describe the Injury	Date of Injury OR Approx. Age

Healthy Living History:

Do you exercise? □Yes □ No How often? ____

Do you smoke? □ Yes □ No How much? ____

Do you drink alcohol? □ Yes □ No How much/week? ____

Any coffee/caffeine? □ Yes □ No How many cups/day? ____

Any supplements (i.e. vitamins, minerals, herbs)? ____

On a scale of 1-10 (10 being "great"), how would you rate your quality of sleep? ____

On a scale of 1-10 (10 being "great"), how would you rate your overall energy level? ____

On a scale of 1-10 (10 being "high"), how would you rate your overall level of stress? ____

On a scale of 1-10 (10 being of most value), how healthy do you feel overall? ____

On a scale of 1-10 (10 being of most value), how committed are you to improving your overall health and wellness? ____

What is your current weight? _________________ Desired Weight? _________________

If your condition(s) was corrected, what would you be able to do better?

Occupational History

Occupation:____________________________

Duties you regularly perform:____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on your body?

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^#DATE#^

Past Medical History:

Please list any medications: ______________________________

Primary Medical Doctor: ______________________________ Phone number: ______________

Please list past surgeries including dates: ______________________________

"Car accidents and other traumas can cause damage to the spine and nerves", please describe:

The date of your most RECENT Car Accident: ______________________________

Any Chance of Pregnancy? Yes No Not Applicable

Family History

Please list Name, Age, and Health of:

Father:______________ Mother:______________ Siblings: ______________

Spouse:______________ Children:______________________________

Does anyone in your family suffer with the same condition(s)? □ yes □ no

If yes whom: □ grandmother □ grandfather □ mother □ father □ sister □ brother □ son □ daughter

Are there other family conditions the doctor should be aware of? □ yes □ no If yes, please list those conditions here:

____

Review of Systems Relating to Nerve Stress:

Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called ***Subluxations*** (sub-lux-a-shuns). It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted **POSTURE**. Postural distortions have many serious and adverse affects on your overall health.

Please check any health conditions you may be experiencing, now or in the past.

CERVICAL SPINE (NECK):

Postural distortions from **subluxations**, in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Do you experience…?

□ Neck Pain
□ Pain into your RIGHT shoulders/arms/hands
□ Numbness/tingling in RIGHT arms/hands
□ Pain into your LEFT shoulders/arms/hands
□ Numbness/tingling in LEFT arms/hands
□ Hearing disturbances/Ringing
□ Weakness in grip
□ Changes in weight

□ Headaches
□ Dizziness
□ Visual Disturbances
□ Prior Stroke
□ Coldness in hands
□ Thyroid conditions
□ Inner Tension/Nervousness
□ Slurred Speech

□ Sinusitis
□ Allergies/Hay Fever
□ Recurrent Colds/Flus
□ Low Energy/Fatigue
□ TMJ/Pain/Clicking
□ Neck Disc Problems
□ Fibromyalgia
□ Poor Sleep

THORACIC SPINE (UPPER BACK):

Postural distortions from **subluxations** in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

□ Heart Palpitations/Murmurs
□ High Blood Pressure
□ Shortness of Breath

□ Recurrent lung infections
□ Asthma/wheezing
□ Heart attacks/Angina

□ Bronchitis
□ Tachycardia/Fast heart rate
□ Pain on deep breathing

^#DATE#^

THORACIC SPINE (MID BACK):

Postural distortions from **subluxations** in the mid back will weaken the nerves in your ribs/chest and upper digestive tract and affect these parts of your body. Do you experience…?

□ Mid back pain
□ Pain into your ribs/chest
□ Ulcers/Gastritis
□ Hypoglycemia
□ Nausea
□ Tired/irritable after eating or when you haven't eaten in a while
□ Reflux / Heartburn
□ Diabetes

LUMBAR SPINE (LOW BACK):

Postural distortions from **subluxations** in the low back will weaken the nerves in your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

□ Low back pain
□ Pain into your RIGHT hips/legs/feet
□ Numbness/tingling in your RIGHT legs/feet
□ Pain into your LEFT hips/legs/feet
□ Numbness/tingling in your LEFT legs/feet
□ Muscle cramps in your legs/feet
□ Weakness/injuries in your hips/knees/ankles
□ Menstrual irregularities/cramping (females)
□ Recurrent Bladder Infections
□ Coldness in your legs/feet
□ Frequent/difficulty urinating
□ Constipation/Diarrhea
□ Sexual Dysfunction
□ Lumbar Disc problems
□ Cancer

Please list any health conditions not mentioned:

Reviewed with patient on __________ by ______________________________. Signature_______________________

Patient Signature ______________________________

AUTHORIZATION TO RECEIVE MEDICAL RECORD INFORMATION

OVIEDO MEDICAL CLINIC, LLC dba SYNERGY OVIEDO CHIROPRACTIC is hereby authorized to request the release of any medical records, laboratory test results, and radiographic & diagnostic imaging results, pertinent to the health care of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

OVIEDO MEDICAL CLINIC, LLC dba SYNERGY OVIEDO CHIROPRACTIC is also authorized to release any medical records pertinent to the health care of the above named patient to, but not inclusive of, any insurance carrier, adjustor, attorney, health care provider, or immediate family member, upon receipt of the signature of the above named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by said OVIEDO MEDICAL CLINIC, LLC dba SYNERGY OVIEDO CHIROPRACTIC

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Eric Janowitz and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Eric Janowitz, including those working at the clinic

I understand I will have the opportunity to discuss with the doctors of Synergy Oviedo Chiropractic, and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. 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, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

YOUR FINANCIAL RESPONSIBILITY

Payment is due when services are rendered unless prior arrangements (including insurance participation) have been made. The individual(s) above understands that a $30 returned check fee will be charged should payments be made via check. The above individual(s) will also be responsible for any appropriate collection or attorney's fees which may accrue if it is necessary to engage collection services to pursue payment of any outstanding balance.

Patient Name: ______________________________________

______________________________________ ____________________
Signature of patient or parent/legal guardian Date

______________________________________ ____________________
Witness of patient or guardian's signature Date

^#DATE#^

Synergy Cj]YXc 7\]fcdfUWh]W
Patient Health Information Privacy Agreement
Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Synergy Cj]YXc 7\]fcdfUWh]W** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Synergy Cj]YXc 7\]fcdfUWh]W** I understand that diagnosis or treatment of me by **Eric Janowitz.D.C**. or other doctors at Synergy Oviedo Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Synergy Cj]YXc 7\]fcdfUWh]W** is not required to agree to the restrictions that I may request. However, if **Synergy Cj]YXc 7\]fcdfUWh]W** agrees to a restriction that I request, the restriction is binding on **Synergy Cj]YXc 7\]fcdfUWh]W** and **Eric Janowitz. D.C.** Unless Synergy Oviedo Chiropractic is notifiedotherwise, I consent to being contacted by Synergy Oviedo Chiropractic by telephone, mail, or other electronic means in order to confirm appointments, advise me of any shift closings, provide newsletters, or invite me to any special events. I also consent to having my picture taken in order for the doctors to help analyze my posture.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Eric Janowitz. D.C.** or **Synergy Cj]YXc 7\]fcdfUWh]W** has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in one of our closed private exam rooms. A doctor or trained staff member is happy to speak with you about your condition or other matters in the closed private exam room upon your request.

Our office has an open, family-centered approach to wellness and we believe it is in all our patient"s best interests to have the support and cooperation of their families. Therefore, our office strongly encourages that the spouse or significant other be present when the doctor goes over the patient"s report and recommendations for treatment and wellness. If you object to the presence of your spouse or significant other at your report, please let us know immediately so we can best determine how best to serve you including making special arrangements or, if necessary, refer you to another chiropractor.

In addition, we may disclose your PHI to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

I understand I have a right to review and a copy has been provided to me, upon my request, **Synergy Cj]YXc 7\]fcdfUWh]Wg** Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Synergy Oviedo Chiropractic. The Notice of Privacy Practices for Synergy Oviedo Chiropractic is provided at 1791 East Broadway, Oviedo, FL 32765.

This Notice of Privacy Practices also describes my rights and the **Synergy Cj]YXc 7\]fcdfUWh]Wg** duties with respect to my protected health information.

Synergy Cj]YXc 7\]fcdfUWh]W reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of Patient or Personal Representative	Date
Signature of Patient or Personal Representative	Description of Personal Representative's Authority