SYNERGY
Health & Wellness

# Chiropractic Case History/Patient Information

Patient Name:_____ Date:_____

Social Security #_____ Birth Date: ___/___/___ Age:_____ Gender: F M

E-mail address:_____ Cell Phone:_____

Preferred method of appointment reminder: ☐ Email ☐ Text Cell Phone Provider_____

Height:_____ Weight:_____ Specify Right or Left Handed:_____

Have you ever been in our office before? ☐ Yes ☐ No

If you are under 18 years of age, who are your legal parents or guardian?

Father:_____ Date of Birth: ___/___/___ Phone: _____

Mother:_____ Date of Birth: ___/___/___ Phone: _____

Guardian:_____ Date of Birth: ___/___/___ Phone: _____

Marital Status: ☐ Married ☐ Separated ☐Widowed ☐Single How many children? _____

CURRENT ADDRESS

Street _____

City_____ State_____ Zip_____

Occupation_____ Employer_____

Work Address_____ Work Phone _____

Student at_____ ☐ Full Time ☐ Part Time

Name of Spouse_____ Spouse's Date of Birth : ___/___/___

Who should we contact in the event of an emergency_____ Phone Number _____

Please check any and all insurance coverage that may be applicable in this case:

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

☐ Major Medical ☐Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____
Full name of Policy Holder _____ Policy Holder's Date of Birth: ___/___/___

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Method of payment for today's charges: ☐Cash ☐Check ☐Credit Card/Debit Card

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____



28963 SR 54 Wesley Chapel, FL 33543 (813) 906-2499 F: (813) 343-6093

## HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared:_____

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache ☐ Throbbing

What caused it?_____

What aggravates it? _____

What relives it? _____

Days lost from work:_____

Have you ever had the same or a similar condition? ☐Yes ☐No

If yes, when ___/____/____

Describe:_____

Please indicate any other healthcare providers that you have seen for the current conditions or symptoms for which you are seeking treatment:

| Name | Type of Licensure | Date of Last Visit |
|---|---|---|
| _____ | _____ | ___/____/____ |
| _____ | _____ | ___/____/____ |

Please check any of the following symptoms/conditions you have **now (N)** or have had **previously (P)**:

| | N | P | | N | P |
|---|---|---|---|---|---|
| Headaches | ☐ | ☐ | Loss of Balance | ☐ | ☐ |
| Frequency_____ | | | | | |
| Neck Pain | ☐ | ☐ | Fainting | ☐ | ☐ |
| Stiff Neck | ☐ | ☐ | Loss of Smell | ☐ | ☐ |
| Sleeping Problems | ☐ | ☐ | Loss of Taste | ☐ | ☐ |
| Back Pain | ☐ | ☐ | Unusual Bowel Patterns | ☐ | ☐ |
| Nervousness | ☐ | ☐ | Feet Cold | ☐ | ☐ |
| Tension | ☐ | ☐ | Hands Cold | ☐ | ☐ |
| Irritability | ☐ | ☐ | Arthritis | ☐ | ☐ |
| Chest Pains/Tightness | ☐ | ☐ | Muscle Spasms | ☐ | ☐ |
| Dizziness | ☐ | ☐ | Frequent Colds | ☐ | ☐ |
| Shoulder/Neck/Arm Pain | ☐ | ☐ | Fever | ☐ | ☐ |
| Numbness in Fingers | ☐ | ☐ | Sinus Problems | ☐ | ☐ |
| Numbness in Toes | ☐ | ☐ | Diabetes | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Indigestion Problems | ☐ | ☐ |
| Difficulty Urinating | ☐ | ☐ | Joint Pain/Swelling | ☐ | ☐ |
| Weakness in Extremities | ☐ | ☐ | Menstrual Difficulties | ☐ | ☐ |
| Breathing Problems | ☐ | ☐ | Weight Loss/Gain | ☐ | ☐ |
| Fatigue | ☐ | ☐ | Depression | ☐ | ☐ |
| Lights Bother Eyes | ☐ | ☐ | Loss of Memory | ☐ | ☐ |
| Ears Ring | ☐ | ☐ | Buzzing in Ears | ☐ | ☐ |
| Broken Bones/Fractures | ☐ | ☐ | Circulation Problems | ☐ | ☐ |
| Rheumatoid Arthritis | ☐ | ☐ | Seizures/Epilepsy | ☐ | ☐ |
| Excessive Bleeding | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ |
| Osteoarthritis | ☐ | ☐ | Osteoporosis | ☐ | ☐ |
| Pacemaker | ☐ | ☐ | Heart Disease | ☐ | ☐ |
| Stroke | ☐ | ☐ | Cancer | ☐ | ☐ |
| Ruptures | ☐ | ☐ | Coughing Blood | ☐ | ☐ |
| Eating Disorder | ☐ | ☐ | Alcoholism | ☐ | ☐ |
| Drug Addiction | ☐ | ☐ | HIV Positive | ☐ | ☐ |
| Gall Bladder Problems | ☐ | ☐ | Ulcers | ☐ | ☐ |



28963 SR 54 Wesley Chapel, FL 33543 (813) 906-2499 F: (813) 343-6093

Have you experienced RECENT CHANGES to:

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder
☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite
Please explain: _____

Serious illnesses or conditions not listed above? _____
When?_____

What prior surgery have you had?

1)_____ ___/___/____
2)_____ ___/___/____
3)_____ ___/___/____

What medications or drugs are you taking?_____

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If yes, describe:_____

Do you have any allergies of any kind? ☐ Yes ☐ No

If yes, describe:_____

Do you have any Congenital Condition? ☐Yes ☐ No If YES, Describe _____

Do you smoke? ☐Yes ☐ No If Yes, number of packs _____

Do you drink? ☐Yes ☐ No If Yes, number of drinks _____

WOMEN ONLY: ☐ There is a possibility I may be pregnant ☐Yes, I am definitely pregnant
☐No, I am definitely not pregnant

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1)_____ ___/___/____
2)_____ ___/___/____
3)_____ ___/___/____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____ Date: _____



28963 SR 54 Wesley Chapel, FL 33543 (813) 906-2499 F: (813) 343-6093

SYNERGY
Health & Wellness

# Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)



28963 SR 54 Wesley Chapel, FL 33543 (813) 906-2499 F: (813) 343-6093

SYNERGY
Health & Wellness

# INFORMED CONSENT

William Abrahams, D.C.
28963 State Road 54, Wesley Chapel, FL 33543
813-906-2499

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc 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, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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

Name of Patient:_____
Signature of Patient:_____
Date:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____
Guardian/Parental Signature:_____
Date:_____

SYNERGY
Health & Wellness

# OFFICE POLICIES

**METHOD OF PAYMENT:**

Payment is due at the time of service. It is our office policy to collect 100% payment for any deductibles, co-pays, co-insurance and non- covered charges at EACH visit. We accept all forms of payment: CASH, PERSONAL CHECK*, CREDIT/ DEBIT CARDS, FSA/HSA CARDS.

* Returned checks will be subject to a $25.00 collection charge in addition to the original check amount.

INITIALS _____

**FEE SCHEDULE:**

Our office has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

a) We are a participating provider in your health plan network.
b) You are covered by a State or Federal program with a mandated fee schedule.
c) You are a member of Preferred Chiropractic Doctor (PCD), or any other Discount Medical Plan Organization we may join. PCD is NOT an insurance company. Patients who are uninsured, or underinsured (have limited benefits for chiropractic care) may join PCD in our office or online and be entitled to network discounts similar to our insured patients. PCD is a nationwide membership program for patients that have no insurance or for those that wish to pay for services rendered at each visit. Membership is $37.00 per year and covers you and your dependent family. This allows us to legally lower our fees while continuing to stay compliant with local and federal rules and guidelines. Members of PCD pay lower fees that are NOT REIMBURSABLE through insurance companies.
d) Patients who are having financial difficulties may qualify for a reduction in a repayment plan or a financial adjustment on their account as detailed in our Hardship Policy and Application. They will be required to complete a financial form and include the necessary financial documentation to process their application.
e) As part of our compliance program, our office will be unable to extend discounts other than those listed above.

We itemize every procedure so the charges per visit may vary. These charges depend on the individual needs of the patient. We will bill for all services rendered.

INITIALS _____

**HEALTH/MEDICAL INSURANCE:**

You must provide us a copy of your health insurance card. If we are contracted with your insurance plan, we will submit your insurance claims. However, your insurance policy is an agreement between you and your insurance company. It is important that you understand your health benefits listed in your policy. There are many variations in insurance policies. Monitoring any policy limitations is considered the responsibility of the patient. As a courtesy to our patients, our office will attempt to verify coverage and benefits, BUT THIS IS NOT A GUARANTEE OF PAYMENT. Our office will do our best to ESTIMATE what your patient portion will be at each visit. You will be sent a statement for any difference in the amount paid at each visit and the actual amount due once your claims have been

processed and paid. If your health plan determines a service "non-covered", you will be responsible for the complete charge or balance of non-covered charge.

INITIALS _____

**EPAY STATEMENT ELECTION/AUTHORIZATION:**

For patient convenience, we offer E-Pay Statements. This allows the patient to pay a statement via a secure payment link sent via either text or email. To authorize E-Pay Statements, please mark your preferred delivery method:

☐ Text Cell Phone Number:_____

☐ Email Email Address:_____

☐ I DO NOT Authorize E-Pay Statements. *Statements will be mailed USPS

INITIALS _____

**MISSED APPOINTMENT POLICY:**

If you need to cancel or re-schedule an appointment, please allow us the courtesy of 24 hours notice so that we may schedule someone else in need at that time. If it is a continual problem there will be a $20.00 charge added towards your account and the patient will be responsible for payment.

INITIALS _____

_____ _____

Patient Name Date

## NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

**Instructions:** The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
**Examiner**

**OTHER COMMENTS:** _____

With Permission from: Bolton JE, Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

**BACK BOURNEMOUTH QUESTIONNAIRE**

Patient Name _____ Date _____

**Instructions:** The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
**Examiner**

**OTHER COMMENTS:** _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.