



**Synergy Medical**  
 16705 Square Drive  
 Marysville, Ohio 43040

**Pregnancy Health History Form**

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
 Check appropriate box:  Minor  Single  Married  Divorced  Widowed  Separated  
 SS#/ SIN \_\_\_\_\_  
 Email \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Patient's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer Name \_\_\_\_\_  
 Spouse or Patients' Guardian Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**Responsible Party**

Name of the person responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Is the person currently a patient at our office?  Yes  No  
 Email \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Driver's License # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Do you have Medical Insurance?  Yes  No if yes, complete the following:  
 Name of the insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Name of Employer \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS  
 AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS Y PERSONAL REPRESENTATIVE  
 AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Synergy Medical, Doctor Charita Cooper, Doctor Patrick Cooper, Mackenzie MacKenzie CNP, and Lindsay West, CNP** as well as all employees, employers, representatives, and agents thereof (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with the same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that the Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Providers. A photocopy or scan of this document is to be considered as valid as the original.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. X \_\_\_\_\_ (SEAL)  
 \_\_\_\_\_ (Patient signature)  
 X \_\_\_\_\_ (SEAL) X \_\_\_\_\_  
 \_\_\_\_\_ (Signature of Guardian if applicable) \_\_\_\_\_ (Please print patient name)

**Current Health Concern** (if there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box) None

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**About Your Pregnancy:** (check answer)

Is this your first pregnancy?  Yes  No

If this is not your first, how many times have you been pregnant? \_\_\_\_\_

Have you had any complications with previous pregnancies?  Yes  No

If yes, please explain \_\_\_\_\_

If you have had miscarriage(s), how far along in your pregnancy did it occur?

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Was this pregnancy planned?  Yes  No

What is the estimated date of delivery? \_\_\_\_\_

Who is your primary caregiver for delivery?  Obgyn  GP  Midwife Name: \_\_\_\_\_

What is your planned location for delivery?  Hospital  Home  Birthing clinic  Other: \_\_\_\_\_

How do you feel about this pregnancy? \_\_\_\_\_

Have you a birth plan?  Yes  No

Would you like information on creating one?  Yes  No

Any special arrangements for the birth? (planned C-sec, water delivery, birth chair, squat, other) \_\_\_\_\_

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Would you like additional information on options for birth posturing?  Yes  No

Have you had any testing? Genetic, blood, ultrasound, amniocentesis, chorionic villi sampling, other)?

Dates and reasons: \_\_\_\_\_

Are you planning on breastfeeding post delivery?  Yes  No

Would you like further information on the advantages of breastfeeding?  Yes  No

Was your blood pressure prior to pregnancy within normal range, low or high? \_\_\_\_\_

What is your present blood pressure and when was it last checked? \_\_\_\_\_

Have you changed your diet/menu since learning of your pregnancy?  Yes  No

Would you like further information on healthy nutrition for pregnancy?  Yes  No

Have you smoked prior to or along with this pregnancy?  Yes  No  Quit \_\_\_\_\_

Have you had alcohol during this pregnancy?  Yes  No

**Have you noticed:**

Swelling in the arms or legs?  Yes  No

Low back pain?  Yes  No How often? \_\_\_\_\_

Upper back pain?  Yes  No How often? \_\_\_\_\_

Neck pain?  Yes  No How often? \_\_\_\_\_

Rib or chest pain?  Yes  No How often? \_\_\_\_\_

Any foot pain?  Yes  No How often? \_\_\_\_\_

Digestive complaints? Heartburn, constipation?  Yes  No How often? \_\_\_\_\_

Nausea or vomiting?  Yes  No Frequency and when? \_\_\_\_\_

Arm or hand numbness/tingling?  Yes  No How often? \_\_\_\_\_

Dizziness or lightheadedness?  Yes  No How often? \_\_\_\_\_

Headaches?  Yes  No How often? \_\_\_\_\_

Pain radiating down the leg(s)?  Yes  No How often? \_\_\_\_\_

Heart palpitations?  Yes  No How often? \_\_\_\_\_

If pain from anything noted above is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) Check or describe its character:

Sharp  Dull  Burning  Tingling  Throbbing  Spasms  Other: \_\_\_\_\_

When did you notice it? \_\_\_\_\_

What happened? \_\_\_\_\_

What relieves? \_\_\_\_\_

What aggravates? \_\_\_\_\_

Does it radiate or cause problems elsewhere? \_\_\_\_\_

Any associated or related concerns? \_\_\_\_\_

Name of Professionals seen for this: \_\_\_\_\_

Treatment and results: \_\_\_\_\_

**Other health concerns:** Please note all other health concerns present or in the past.

**Diseases history:** (Check all that apply)

- |  |   |   |   |   |
|--|---|---|---|---|
| <input type="checkbox"/> Stuffy nose         | <input type="checkbox"/> Runny sinuses    | <input type="checkbox"/> Frequent colds           | <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Lowered resistance  | <input type="checkbox"/> Loss of balance  | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Indigestion      | <input type="checkbox"/> Bloating                 | <input type="checkbox"/> Appendicitis             | <input type="checkbox"/> Pneumonia          |
| <input type="checkbox"/> Bleeding disorders  | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Cataracts                | <input type="checkbox"/> Vision changes           | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Migraines          |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Difficulty digestion     | <input type="checkbox"/> Loose stools             | <input type="checkbox"/> Hernia             |
| <input type="checkbox"/> Herniated Disc      | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Multiple Sclerosis       |   |
| <input type="checkbox"/> Osteoarthritis      | <input type="checkbox"/> Ulcers           | <input type="checkbox"/> Osteoporosis             | <input type="checkbox"/> Rheumatoid arthritis     |   |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid problem  | <input type="checkbox"/> Tonsillitis              | <input type="checkbox"/> Urinary tract infections |   |
| <input type="checkbox"/> Other (list): _____ |   |   |   |   |

**Drug Allergies:**

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**Physical stresses:**

Any significant injuries, falls or traumas during infancy or childhood?  Yes  No  Unsure

If yes, please explain \_\_\_\_\_

Any significant injuries, falls or traumas (car accidents) during adulthood?  Yes  No  Unsure

If yes, please explain \_\_\_\_\_

Any hospital visits?  Yes  No

If yes, please explain \_\_\_\_\_

Have you had any surgeries?  Yes  No

If yes, please explain with dates \_\_\_\_\_

Any fractured bones or dislocations?  Yes  No

If yes, please explain with dates \_\_\_\_\_

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving)  Yes  No  Unsure

If yes, please explain \_\_\_\_\_

Any hobbies that are physically strenuous or, have repetitive movements?  Yes  No  Unsure

If yes, please explain \_\_\_\_\_

What is your usual exercise routine? \_\_\_\_\_

Any vehicle accidents?  Yes  No

What happened and when \_\_\_\_\_

### Chemical Stresses:

Are you taking prescription or over-the-counter medications?  Yes  No

If yes, what you are taking and why \_\_\_\_\_

Are you currently taking supplements?  Yes  No  Unsure

If yes, which ones and why? \_\_\_\_\_

Do you drink bottled water?  Yes  No  Occasionally

Are you exposed to pollutants, strong smells, chemicals, aerosols?  Yes  No  Occasionally

Do you eat organic?  Yes  No  Occasionally

Do you use natural or environmentally friendly products in your home? I.E. Cleaning supplies, hair and makeup, etc.  Yes  No

Do you drink or bathe/shower in chlorinated water?  Yes  No

### Mental/Emotional Stresses:

Since psychological stress has been shown to affect numerous systems and fetal function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being minimal to 10 being extreme)

Life in general I feel \_\_\_\_\_ Work and Career I feel \_\_\_\_\_ Time management I feel \_\_\_\_\_

Sports & hobbies I feel \_\_\_\_\_ Health and well-being I feel \_\_\_\_\_ Quality of sleep I feel \_\_\_\_\_

About my pregnancy I feel \_\_\_\_\_ Relationships I feel \_\_\_\_\_ Financial stress I feel \_\_\_\_\_

If you are experiencing significant or ongoing stress please explain \_\_\_\_\_

Do you practice some form of meditation, breath work, other mind-body movement or have a routine to reduce your stress?

Yes  No

If yes, please explain \_\_\_\_\_

Are you interested in learning about stress reduction practices?  Yes  No

### Family Health History:

Please note any health issues that are present with family members such as parents, siblings, significant other or children.

Cancer, hypertension, stroke, arthritis, kidney disease, dementia, diabetes, other

**Why are you here?** *People seek chiropractic care for a number of reasons and have certain expectations and perceptions.*

*Please check the goals which apply to you so we can accommodate your wishes.*

- Improvement in function
- Pain reduction
- Improved quality of life
- Relief
- Longevity
- Manage my crisis
- Stress reduction
- Keep me moving
- Full body integration
- Information on prevention
- Longevity
- Improved performance
- Wellness
- Symptom management
- Healthier immune system
- Optimum function and quality of life
- Other: \_\_\_\_\_

# CONSENT TO TREAT

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read below and if you have any questions, please feel free to ask.

## AUTHORIZATION TO GIVE MEDICAL CARE-CONSENT TO TREATMENT:

I hereby voluntarily consent to outpatient care from Synergy Medical encompassing routine diagnostic procedures, physical examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications prescribed by the providers (joint injections, PRP, trigger point injections, regenerative cell medicine). I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Synergy Medical's medical providers and staff, as is necessary in the medical staff's judgement. I understand that during the course of treatment, health care workers may be exposed to the patient's blood and/or body fluids increasing the risk of contracting Hepatitis B, Hepatitis C and/or HIV. In the event that exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the healthcare worker. I understand that this consent will be valid and will remain in effect as long as I attend the clinic. Please see below for potential risks and side effects.

- Injection: increased pain or discomfort, infection, allergic reactions, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, hematoma formation, collapsed lung, seizures, even remote risk of death or serious disability that exist with any surgical procedure.
- Blood Draw: increased pain or discomfort, infection, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, or hematoma formation.
- Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.
- Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.
- Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

### Consent to Evaluate and Treat a Minor:

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms and hereby grant permission for my child to receive treatment with Synergy Medical.

### Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

No One     Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

May we leave messages regarding your personal healthcare information on an answering device, i.e. home answering machines or voicemails? Yes  No

### Acknowledgment

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Patient Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name Print: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Women Only:

To the best of my knowledge, I **am/am NOT** pregnant and (**give my permission/don't give my permission**) to x-ray me for diagnostic interpretation.

**Synergy Medical**

16705 Square Dr. Marysville, OH 43040  
(937)642-4400 (p) ~ (937)642-4443 (f)

**Protecting Your Health Information**

**New Regulation Passed**

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individuals and medical records.

**Our Pledge Regarding Medical Information**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need the record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

**Disclosure of Medical Information**

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

**Your Rights**

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

**Open Adjusting Concept**

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may include anything concerning the primary health care of that patient.

**Notification by Mail or Phone**

Patients may be contacted by mail, email, or phone unless written notification is requested that contact be only in person.

**Complaints**

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Mackenzie MacKenzie, CNP • Lindsay West, CNP • Charita N.Cooper, DC CACCP • Patrick S. Cooper, DC CCEP**

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my primary care physician of my condition, treatment and expected/actual response to care at this office.

Patient/Guardian Signature: \_\_\_\_\_

Name (Please Print): \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Physician's Address/Phone: \_\_\_\_\_

\_\_\_\_\_