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, Alana Grabovich 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 or 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

____

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?

____

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)_______________

____

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 you 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)

▢ Stuffy nose	▢ Runny sinuses	▢ Frequent colds	▢ Bronchitis	▢ Ulcerative colitis
▢ Lowered resistance	▢ Loss of balance	▢ Difficulty concentrating	▢ Fatigue	▢ Asthma
▢ Emphysema	▢ Indigestion	▢ Bloating	▢ Appendicitis	▢ Pneumonia
▢ Bleeding disorders	▢ Cancer	▢ Cataracts	▢ Vision changes	▢ Diabetes
▢ Hypoglycemia	▢ Epilepsy	▢ Heart Disease	▢ Hypertension	▢ Migraines
▢ Hepatitis	▢ High cholesterol	▢ Difficulty digestion	▢ Loose stools	▢ Hernia
▢ Herniated Disc	▢ Kidney Disease	▢ Liver Disease	▢ Multiple Sclerosis	
▢ Osteoarthritis	▢ Ulcers	▢ Osteoporosis	▢ Rheumatoid arthritis	
▢ Parkinson's D**isease**	▢ Thyroid problem	▢ Tonsillitis	▢ Urinary tract infections	

▢ Other (list):____

Drug Allergies, including reaction to them:

____

____

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 repetitiv**e** 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

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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.

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 be entering your name and email into our database.

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:_______________

PHOTO/VIDEO RELEASE FORM

Permission to Use Photograph/Video

I grant Synergy Medical, its representatives and employees the right to take photographs of me and my property in connection with the above identified subject. I authorize Synergy Medical , its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Synergy Medical may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.

I have read and understand the above:

Signature_____________________________________

Printed Name________________________________

Date____

Signature, parent or guardian_____________________________

(If under age 18)

Alana Grabovich, 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:____

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