Synergy Medical
16705 Square Drive
Marysville, Ohio 43040

Pediatric Intake

Patient Name_____ **DOB:**_____ ▢ **Male** ▢ **Female**
SS#/ SIN_____
Email_____ Home Phone_____ Cell Phone_____
Patient's Address_____ City_____ State_____ Zip_____
Parent/Guardian Name_____ Parent/Guardian'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 (skip rest of this section) ▢ 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_____

In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

_____ _____
Parent or Guardian Date

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_____
(Patient signature)

X_____ X_____
(Signature of Guardian if applicable) (Please print patient name)

Present Health Concerns

Major:_____

Minor:_____

When did this problem begin?_____

Is this problem: ▢ Occasional ▢ Frequent ▢ Constant ▢ Intermittent

Does this problem radiate? ▢ Yes ▢ No If Yes, where?_____

What makes this worse?_____

What makes this better?_____

Is the problem worse during a certain time of the day? ▢ Yes ▢ No If Yes, when?_____

Does this interfere with the child's sleep? ▢ Yes ▢ No Eating? ▢ Yes ▢ No

Is this becoming worse? ▢ Yes ▢ No Daily routine? ▢ Yes ▢ No

Often seemingly unrelated symptoms can manifest as other health concerns.. Please check if your child has had any of the following:

▢ Headaches	▢ Chest pressure	▢ Weight loss
▢ Dizziness	▢ Breast pain	▢ Weight gain irritability
▢ Frequent colds	▢ Dental problems	▢ Fatigue
▢ Sinus congestion	▢ Fevers depression	▢ Sore throats
▢ Heart palpitations	▢ Loss of balance	▢ Ear pain/infections
▢ Numbness in feet	▢ Loss of concentration	▢ Asthma
▢ Numbness in hand(s)	▢ Fainting	▢ Cold sweats
▢ Weakness	▢ Ears buzzing	▢ Bronchitis
▢ Heartburn	▢ Poor coordination	▢ Pneumonia
▢ Muscle cramps	▢ Vision changes	▢ Difficulty breathing
▢ Upper back pain	▢ Loss of memory	▢ Shortness of breath
▢ Neck pain	▢ Loss of smell	▢ Low back pain
▢ Loss of taste	▢ Constipation	▢ Radiating pain
▢ Light sensitivity	▢ Diarrhea	▢ Sleeping problems
▢ Face flushed	▢ Urinary problems	▢ Numbness in leg(s)
▢ Reduced mobility	▢ Bloating/gas	▢ Stiffness
▢ Other:_____		

Drug Allergies:

_____

_____

Birth History

What was the child's gestational age at birth? _____ Weeks

Birth weight:_____ lbs _____oz Birth length:_____inches

Was your child's birth: ▢ At home ▢ In a birthing center ▢ Hospital ▢ Other

Was the birth considered: ▢ Medical ▢ Midwife Duration of birth:_____hours

Was child born: ▢ Cephalic (head first) ▢ Breech (feet first)

Were there any complications? ▢ Yes ▢ No If Yes, please explain_____

Assistances used during delivery: ▢ Forceps ▢ Vacuum extraction ▢C-section ▢ Episiotomy

Was labour: ▢ Spontaneous ▢ Induced

Were medications or epidurals given to the mother during birth? ▢ Yes ▢ No

APGAR score: At Birth____/10 After 5 minutes____/10

Is there anything else we need to know about this birth? ▢ Yes ▢ No

Growth & Development

Was the infant alert and responsive within 12 hours of delivery? ▢ Yes ▢ No

If no, please explain_____ At what age did the child: Respond to sound:_____ Follow an object:_____

Hold up head: _____ Vocalize: _____

Sit alone: _____ Teethe: _____

Crawl: _____ Walk: _____

Does your child sleep: ▢ Front ▢ Back ▢ Side

Do you consider the child's sleeping pattern normal? ▢ Yes ▢ No How many hours per day?_____

If no, please explain_____

Family Health History

Please note any health problems (ie: cancer, hereditary conditions, diabetes, heart disease) that are present in:

Mothers family:_____

Fathers family:_____

Siblings:_____

Physical Stressors

Since problems that chiropractors look for and detect can be related to many types of stressors, the following information is also very important to us.

Any trauma to the mother during pregnancy? (ie, falls, accidents, etc.) ▢ Yes ▢ No

If yes, please explain_____

Any evidence of birth trauma to the infant?

▢ Bruising ▢ Odd shaped head ▢ Stuck in birth canal ▢ Fast or excessively long birth ▢ Respiratory depression ▢ Cord around neck

Any falls from couches, beds, change tables, etc? ▢ Yes ▢ No

If yes, please explain_____

Any traumas resulting in bruises, cuts, stitches or fractures? ▢ Yes ▢ No

If yes, please explain_____

Any hospitalizations or surgeries? ▢ Yes ▢ No

If yes, please explain_____ Any sports played?_____ Is a school backpack used? ▢ Yes ▢ No Is it heavy or light?_____

Chemical Stressors

Was this child breast-fed? ▢ Yes ▢ No If yes, how long?_____ Formula introduced at what age:_____

Which formula?_____

Introduction of cow's milk at what age: _____

Began solid foods at what age:_____

Types of solid foods:_____

Food/Juice intolerance? ▢ Yes ▢ No Type:_____ Is your child on or have taken any medications? ▢ Yes ▢ No

If yes, when and what type:_____

During the mother's pregnancy:

Did the mother smoke? ▢ Yes ▢ No If yes, How much?_____

Drink alcohol? ▢ Yes ▢ No If yes, How much?_____

Any illnesses during the pregnancy? ▢ Yes ▢ No

If yes, please describe_____

Any supplements taken during pregnancy? ▢ Yes ▢ No

If yes, please describe_____

Any drugs taken during pregnancy? ▢ Yes ▢ No

If yes, please describe_____

Any ultrasounds? ▢ Yes ▢ No If yes, How many?_____

Reasons for being done:_____

Any invasive procedures during pregnancy (ie amniocentesis, Chorionic villi sampling, etc.)?

▢ Yes ▢ No If yes, please explian_____ Any pets at home? ▢ Yes ▢ No

Any smokers in the home? ▢ Yes ▢ No

Any antibiotics given? ▢ Yes ▢ No If yes, reason:_____ Is the diet organic? ▢ Yes ▢ No

Do you use 'green products' in your home for cleaning? ▢ Yes ▢ No

How often do they receive processed foods, white sugar, gluten (flour), dairy in their diet?

▢ Never ▢ On weekends ▢ A few times per week ▢ Daily Nearly each meal ▢ On special occasions

Are you aware of the impact of nutrition on children's behavior? ▢ Yes ▢ No

Would you like information on nutrition for your child? ▢ Yes ▢ No

Psychosocial Stressors

Any difficulties with lactation? ▢ Yes ▢ No If yes, please explain:_____

Any problems with bonding? ▢ Yes ▢ No If yes, please explain:_____ Any behavioral problems? ▢ Yes ▢ No If yes, please explain:_____ Any inattention? ▢ Yes ▢ No If yes, please explain:_____

Any hyperactivity or restlessness? ▢ Yes ▢ No If yes, please explain:_____

Any compulsiveness? ▢ Yes ▢ No If yes, please explain:_____ Any difficulties at daycare or school? ▢ Yes ▢ No If yes, please explain:_____ Any challenges with learning deficiencies? ▢ Yes ▢ No If yes, please explain:_____ Any night terrors, sleep walking, difficulty sleeping? ▢ Yes ▢ No

If yes, please explain:_____

Any prolonged temper tantrums or separation anxiety? ▢ Yes ▢ No

If yes, please explain:_____

Is the child in daycare? ▢ Yes ▢ No Age of child when began daycare?_____ Is there a nanny or regular sitter during the day if both parents work? ▢ Yes ▢ No

Is the child home schooled? ▢ Yes ▢ No By whom?_____

Average number of hours of television per week?_____ Average number of hours of video games per week?_____ Does your child have a cell phone? ▢ Yes ▢ No

How often do they text or use the phone?_____

Do you feel that your child's social and emotional development is normal for their age? ▢ Yes ▢ No

If no, please explain:_____

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:_____

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:_____

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:_____

_____