Synergy Health & Wellness 361 NE Franklin Ave. Bldg C, Bend OR, 97701 (541) 323-3488

PATIENT INFORMATION (Please print clearly) Date_____

Name_____ SSN_____

Address_____ City _____ State_____ Zip_____

Gender Pronoun: She / He / They / Ze / _____ Birth Date: _____

Email:_____

Cell phone:_____ Work/Home phone:_____

Employer:_____Occupation:_____

Emergency Contact Name:_____ Phone:_____

Whom may we thank for referring you?:_____

Your signature agrees to our 24 hour cancellation policy, and acknowledges that any future cancellations made less than 24 hours prior will be subject to a fee equal to the full cost of the missed session. Our system requires a credit card on file to enforce our cancellation policy. Your card will not be charged, except in the case of no-show or cancellation less than 24 hours in advance. Your card will never be charged without notification.

Printed Name _____

Signature_____ Date _____

(parent signature if patient is a minor)

INFORMATION FOR INSURANCE BILLING ONLY Please provide all insurance cards at time of visit

Type of policy (i.e. Health, auto, workers comp): _____

Insured's name: _____ Insured's date of birth: ____/____/_____

Adjuster name and contact: _____

Do you have a secondary Insurance?
If yes—Name of secondary insurance company: _____

ASSIGNMENT AND RELEASE: I certify that I have insurance coverage with the above listed company and assign directly to the providers of Synergy Health and Wellness all insurance benefits. I authorize the use of my signature on all insurance submissions. Additionally, the care provider may use and disclose my health care information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits related services. **My signature below certifies that I agree to pay any deductible, copayment and coinsurance at the time of service, and in the event payment is denied on the above claim. I will assume responsibility for payment of services rendered. (payment plan may be implemented). I am aware that insurance does not cover no-show or late cancellation charges, and I accept full responsibility for any fees related to this occurrence.**

Signature: _____ Date _____

I have read and accepted the privacy practices Sign_____ Date_____

I was offered privacy practices and declined to read Sign_____ Date_____

N/D

What brings you in for this visit?

Have you tried any other therapies/medications/special diets for the above concern? Specify.

Primary Care Physician

Name		Phone #	
Relationship with Physician (i.e. what do you seen them for, when was your last apt, etc.)			

Therapist/Counselor

Name		Phone #	
Relationship with Physician (i.e. what do you seen them for, when was your last apt, etc.)			

Additional Provider (i.e. specialist, psychiatrist)

Name		Phone #	
Relationship with Physician (i.e. what do you see them for, when was your last apt, etc.)			

___ I give my clinician at Synergy Health and Wellness permission to speak with and disclose my treatment-related protected health information with the above named providers. (Please initial)

Have you had recent blood work/labs drawn? (Give approx. date and MD who ordered)

Please list any medications you are currently taking and what condition they are for:

_____

_____

Do you take vitamins or other nutritional supplements: ❒ no ❒ yes
(list):_____

_____

Are you/could you be pregnant?

List any surgeries you have had:

_____

HEALTH HISTORY ***STOP!!!*** ***Read this*** *******(**check all that apply to ***you***)

Do you have PERSONAL history of problems in any of the following...

___ Allergies (to what?)
___ Arthritis
___ Cardiovascular
___ Chronic Headaches
___ Diabetes
___ Eating Disorder
___ Endocrine
___ Gastrointestinal
___ High Blood Pressure
___ High Cholesterol
___ Immune
___ Musculoskeletal
___ Neurological
___ Psychological
___ Reproductive
___ Respiratory
___ Skin Problems
___ Sleep Disorder
___ Urinary
___ Other (explain)

How often do you experience any of these gastrointestinal symptoms?

_____ Heartburn/Esoph.Reflux
_____ Diarrhea
_____ Stomach Pains/Cramps
_____ Bloating Sensation
_____ Intestinal Pains/Cramps
_____ Gas (of Any Kind)
_____ Constipation
_____ Nausea, Vomiting
_____ Painful Elimination
_____

Please circle how you currently feel about your body.

strongly dislike dislike slightly satisfied satisfied very satisfied

DAILY HABITS

What type of exercise do you do regularly: ❒ none ❒ light ❒ moderate ❒ heavy

What do your daily work habits include: ❒ sitting ❒ standing ❒ light labor ❒ heavy labor ❒other:

Do you drink caffeinated beverages: ❒no ❒yes (type and amount):

Do you drink alcohol: _____ drinks per week Do you use other recreational drugs? _____

Is there anything else that may be related to your condition that we have not asked?

Your signature here signifies that all information provided on this form is true to the best of your knowledge, and consents to receiving therapies in our clinic.

Signature: _____ Date: _____

Parent signature if client is a minor: _____