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

PATIENT INFORMATION (Please print clearly)

Name____ Date_______________ SSN___________________

Address____ City _______________ State_______ Zip_______

Preferred Gender Pronoun: She / He / They / Ze / ___________ Birth Date: ________________________

Email:____

Cell phone:________________________________ Work/Home phone:________________________________

Employer:______________________________________ Occupation:_________________________________

Person to contact in case of emergency:___________________________ Phone:_______________________

Whom may we thank for referring you?:____

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):________________________________

____

HEALTH HISTORY

<u>STOP!!!</u>* Read this ****(**check all that apply to ***<u>you</u>***)

allergies (to what?)	hernia	osteoporosis
arthritis	herniated disc	pinched nerves
cancer	immune system problems	reproductive problems
diabetes	mental health disorders	respiratory problems
fractures	migraine headaches	skin problems
gastrointestinal problems	musculoskeletal problems	stroke
heart disease	neurological problems	

Women, are you/could you be pregnant?

Date of last physical exam:________________

Are you currently under a physician's care? If so, who and what for?

List <u>any</u> falls, motor vehicle accidents or other traumas you have been involved in (include dates):

____

____

List any surgeries you have had:

____

____

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DAILY HABITS

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

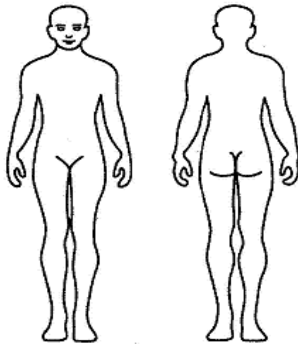
What do your daily work habits include: sitting standing light labor heavy labor other:

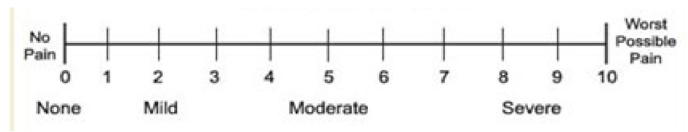
Do you drink caffeinated beverages: no yes (type and amount):

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? ______________________

Have you received massage before? When was your last massage?





Please mark any areas where you feel pain or soreness

What level of pressure do you desire today? Gentle Medium/Firm Very Firm Hard

Your therapist will interact with you to gauge pressure during the session, and to ensure that your needs are being met. Please note that it is ultimately YOUR responsibility to communicate pressure needs during the session. Initial for understanding ________

What level of therapist interaction do you like during session?
Total silence other than to check pressure Chat when I initiate it I like a chatty therapist

What temperature do you like during sessions?
Cool Room Temp/Average Crank up the heat!

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Synergy Health and Wellness is committed to improving your total health. Our providers are happy to work with you to improve the wellbeing of you and your family. Please circle other services that you are interested in learning about today.

Chiropractic Care Mental Health Counseling

Nutrition Counseling Acupuncture

Your signature below certifies that the information you have provided on this intake form is accurate and you agree to accept and pay for treatment. Signature signifies understanding and consent to massage therapy treatment which may in some rare cases carry risks including but not limited to swelling, bruising, joint dislocation, musculoskeletal injury, skin irritation, and other rare complications. Your signature also agrees to the 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.

Printed Name ____

Signature____ Date ________________________

(parent signature if patient is a minor)

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

Type of policy (ie. Auto, workers comp, or health policy): ______________________________________

Name of insurance company:

Insured's name: ________________________________ Insured's date of birth: ____/____/______

Auto Adjuster Name: ________________________ Adjuster Phone # _____________________________

Do you have a secondary insurance? Y N If yes—Name of insurance company:

ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with the above listed company and assign directly to providers of Synergy Health and Wellness all insurance benefits. I authorize 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 co-payment 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 ________________________

NOTICE OF PRIVACY PRACTICES OFFERED (INITIAL ONE)

______ ACCEPTED ______ DECLINED DATE ________________

Clinician Use Only

I acknowledge that I have reviewed this information with the client, and that they are cleared for treatment:

Signed: ____ Date: ________________________