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

NUTRITION COUNSELING AND EDUCATION

PATIENT INFORMATION (Please print clearly) Date_____

Name_____ SSN_____

Address_____ City _____ State_____ Zip_____

Preferred 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?:_____

What brings you in for nutrition counseling?

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

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

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):_____

_____

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

HEALTH HISTORY

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

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

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

Women, are you/could you be pregnant?

Date of last physical exam:_____

List any surgeries you have had:

_____

_____

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?

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 Massage Therapy Mental Health 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 medical nutrition therapy visits. 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 insurance card at time of visit

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

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 _____