Synergy Wellness
409 East 14th Street, Ste.C
New York, NY 10009
Tel: 212-533-4900
Fax: 212-533-4931

First Name_____ **M.I.** _____ **Last Name** _____
Sex _M / F_____ **DOB**_____ **Social Security #** _____
Address _____ **City** _____**State**_____ **Zip**_____
Cell Phone (___)_____ **Email Address**_____

Emergency Contact

First Name _____ Last Name _____ Relationship_____
Phone Number _____

How did you hear about our office? _____

Name of Primary Care Physician _____
Address of Primary Care Physician _____

Is this injury due to an accident? **Yes / No**

☐ Auto Accident ☐ Worker's Comp ☐Other

Current Employer_____
Address_____ City _____ State _____ Zip _____
Phone (___)_____
Date of Injury_____ Time of Injury _____

Late Policy

If a patient is late for an appointment we ask that you call and let us know you are on your way. However, if you are more than ***15 minutes late*** you will have to reschedule your appointment in some cases.

Cancellation of Appointment(s) / No-Shows

Patients wanting to cancel an appointment are asked to call the office 24 hours in advance. The charge for not canceling within a 24 hour notice is **$25.00**, which will be charged to your account and is not payable by any insurance company.

Patients who "No-Show" with no previous notification three times for scheduled appointments may be discharged from the practice.

Signature: _____ Date: _____

For Office Use Only:
NOTES:

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MRI C / L / T **XRAY** C / L / T **EMG** C / L / T **PILLOW** C /L
LASER Yes/ No **TRACTION** Yes/ No **FUNC.EVAL**_____
ORTHCS Yes/ No **TENS / BB** **DENNEROLL** C / L / T
PHYSICAL THERAPY Yes/ No

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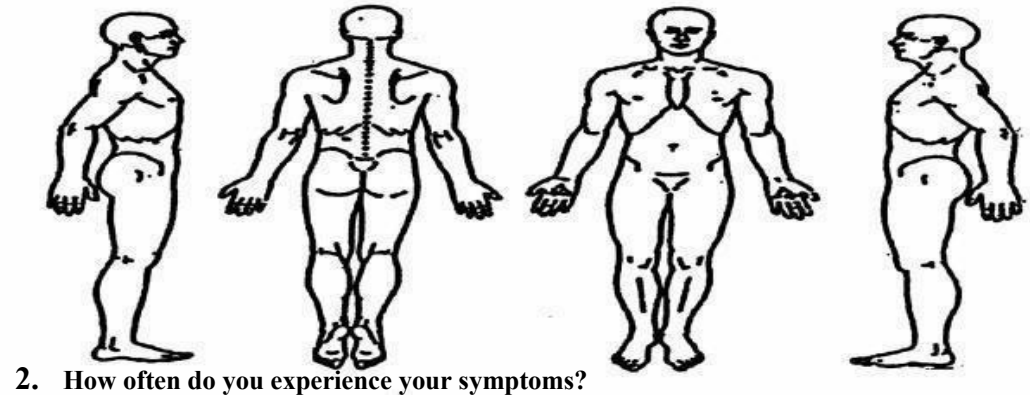
1. Indicate on the drawings below where you have pain/symptoms



2. How often do you experience your symptoms?

□ Intermittently (1-25% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Constantly (76-100% of the time)

3. **How would you describe the type of pain?**

□ Sharp □ Burning □ Tingly
□ Dull □ Shooting □ Sharp with motion
□ Diffuse □ Stiff □ Shooting with motion
□ Achy □ Numb □ Other: _____

4. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. **How much has the problem interfered with your work?**

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ No one
□ Massage Therapist □ Physical Therapist □ Other: _____

9. How long have you had this problem?

Day(s) ____ Week(s)____ Month(s)____ Year(s)____

10. How do you think your problem began? _____

11. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

12. What aggravates your problem? _____

13. What have you tried to alleviate your problems? _____

14. What is your: Height _____ (ft/in) **Weight** _____ (lbs) **Age** _____

15. What is your daily intake of the following?

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□ Caffeine _____ cups/day □ Alcohol _____ drinks/week □ Cigarettes _____ packs/day

16. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

17. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Heart Problems □ Diabetes □ Cancer □ Other_____

18. List all prescription medications you are currently taking:_____

19. List all of the over-the-counter medications you are currently taking: _____

20. List all surgical procedures you have had:_____

21. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day
□ **Other:** _____	□ Most of the day	□ Half of the day	□ A little of the day

22. What activities do you do outside of work? _____

23. Have you ever been hospitalized? □ Yes □ No

If yes, why _____

24. Have you had significant past trauma? □ Yes □ No

If yes, why _____

25. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ Chronic Sinusitis	□	□ Dizziness
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependen
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ High Blood Pressure
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Diabetes
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Asthma
□	□ Arthritis	□	□ Hepatitis		
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		**For Females Only**
□	□ Cancer	□	□ General Fatigue	□	□ Birth Control Pills
□	□ Tumor	□	□ Muscular Incoordination	□	□ Hormonal Replacement
□	□ Visual Disturbances	□	□ Other:	□	□ Pregnancy

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Patient Authorization Record

Initial here

	Authorization for Release of Payment I authorize that direct payment of any benefits available to me be released to Synergy Wellness for services rendered.
	Authorization for Treatment I hereby give authorization for the performance of such rehabilitation & chiropractic procedures as permitted by *(New York State)* Statutes under the appropriate scope of practice are, in the judgment of my Doctor and/or Therapist, deemed necessary.
	Authorization for Release of Information I agree that Synergy Wellness may provide information from my medical record to persons involved in my medical care. I authorize the release of medical information necessary to obtain payment of any benefits available to me to Synergy Wellness for services rendered. I agree that Synergy Wellness may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. I have read "Notice of Privacy Practices" mandated by HIPAA.
	Patient Agreement I agree to pay Synergy Wellness charges for services rendered to me during my course of treatment. I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Synergy wellness collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits I agree that the information given to Synergy Wellness in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Synergy Wellness may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation and No-Fault I agree that the information given to Synergy Wellness in applying for benefits under Workers Compensation or No-Fault is complete and accurate. I agree that Synergy Wellness may give intermediary's information necessary to process claims.

Consent to Care

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with the appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through healthcare procedures from whatever he/she is suffering from which would otherwise not come to the attention of the physician. I affirm that I am not an agent or representative of any insurance company or any other business trying to collect information. All injuries/problems mentioned are true and I am here solely for the treatment of the said problem.

I have read and understand the consent to care.

_____

Patient signature Date

_____

Printed patient name Witness Signature Date

_____

Signature of Legal Representative/POA

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TERMS OF ACCEPTANCE

In the course of chiropractic heath care, it is essential for the physician and patient to work together toward the same objective. As a patient, you should understand the goal and methods of chiropractic that will be used in order to avoid confusion or disappointment.

HEALTH

This is the state of optimal physical, mental and social well-being, not just the absence of disease.

VERTEBRAL SUBLUXATION

A misalignment of one or more of the 24 vertebrae in the spinal column causes alteration of the nerve function and interference of the transmission of mental impulses. Subluxation can impair the bodies' ability to achieve maximum health potential.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek a medical doctor who specializes in that area. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is adjusting to correct vertebral subluxation.

ADJUSTMENT

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

I _____ have read and fully understand the above statements.

All questions regarding the doctors' objectives pertaining to my care in this office have been answered to my satisfaction.
I therefore accept chiropractic care on this basis.

_____ _____
Signature Date

Blue Cross /Blue Shield Patients:

Dr. David Kulla is an out of network provider for Blue Cross/ Blue shield. **It is customary for your insurance company to send YOU checks for reimbursement to our offices, which should be endorsed and returned back to Dr. Kulla.** As a courtesy we submit the bills for the patient to help reduce your out of pocket costs in the office.

For ALL BCBS Members:

Name on Card: _____ Credit Card Number: _____
Expiration date: _____ Security Code: _____

_____ _____
Signature Date

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