

APPLICATION FOR CARE AT

SYNAPSE  CHIROPRACTIC

Today's Date: _____

(Office Use Only) HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: ____ - ____ - ____ Age: _____ Male Female

Address: _____ City: _____ State: _____

Zip: _____ E-mail Address: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Marital Status: Single Married Other Do you have Medicare: Yes No

Employer: _____ Occupation: _____

Emergency Contact: _____ Number: _____ Relationship: _____

If Applicable: Number of Children and Ages: _____

Whom May We Thank for Referring You into Our Office? _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On a scale of **1 to 10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by **circling the number**:

Primary complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is the problem at its worst? AM PM mid-day late PM

How long does it last? It is constant **OR** I experience it on and off during the day **OR** It comes and goes throughout the week

Did a specific event cause the problem(s)? _____

Condition(s) ever been treated by anyone in the past? No Yes, when: _____

By whom? _____

How long were you under care? _____ What were the results? _____

Have you received chiropractic care in the past? No Yes, seen by _____

If anything, what relieves your symptoms? _____

If anything, what makes your symptoms feel worse? _____

Is your problem the result of ANY type of accident? Yes No **If yes-** Auto Related Personal Injury Work Related

Identify *any other injury(s)* to your spine, minor or major, that the doctor should know about:

Identify any *hobbies or leisure activities* affected by your symptom(s):

ACTIVITIES OF DAILY LIVING

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

<u>ACTIVITIES:</u>	<u>EFFECT:</u>		
Carry Children/Groceries/Etc.	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Read/ Concentrate	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Showering/ Bathing	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
House Work (Dishes, Laundry, Etc.)	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Biking	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect/Do Not Perform	<input type="checkbox"/> Painful (still do)	<input type="checkbox"/> Painful (some limits) <input type="checkbox"/> Unable to Perform

Please List Prescription & Non-Prescription Drugs You Take: _____

Patient Signature: _____ Today's Date: ____/____/____

Continued on next page

Please mark ALL symptoms that apply:

C1-C3: ___ Ear/ Sinus Infections ___ Ringing in Ears ___ Hearing Loss ___ Allergies ___ Headaches ___ Double/ Blurred Vision
___ Dizziness/ Fainting ___ ADD/ ADHD ___ Epilepsy/ Seizures/ Convulsions ___ Jaw Pain/ TMJ ___ Trouble Sleeping ___ Focus/ Memory
___ Learning Disabilities ___ High/ Low Blood Pressure ___ Depression

C4-C7: ___ Neck Pain ___ Numbness in Hands, Arms, and/or Fingers ___ Shoulder Pain ___ Speech Challenges
___ Poor Metabolism/ Weight Control ___ Anxiety ___ Frequent Sore Throat/ Strep ___ Tremors

T1- T3: ___ Frequent Colds/ Cough ___ Asthma ___ Heart Problems ___ Lung Problems/ Bronchitis/ Pneumonia ___ Upper Back Pain
___ Chest Pain ___ Pain with Cough or Sneeze ___ Acid Reflux/ GERD

T4- T7: ___ Gallbladder Trouble ___ Heartburn ___ Digestive Problems ___ Ulcers ___ Blood Sugar Problems (High or Low)
___ Liver Problems ___ Mid Back Pain

T8- T12: ___ Excessive Stress ___ Skin Problems/ Acne ___ Irritable/ Mood Changes ___ Kidney Trouble ___ Menstruation Problems
___ Infertility/ Fertility Complications ___ Bed Wetting ___ Pregnancy ___ PMS ___ Menopausal Problems ___ Gas Pain/ Bloating

L1- Sacrum: ___ Hip Pain ___ Low Back Pain ___ Numbness in Legs, Feet, or Toes ___ Impotence ___ Sexual Dysfunction
___ Prostate Problems ___ Colon Trouble ___ Diarrhea/ Constipation ___ Swollen/ Painful Joints ___ Knee Pain
___ Foot/ Ankle Pain ___ Loss of Balance ___ Poor Circulation/ Cold Feet

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk is most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Synapse Chiropractic, A Sahota Corporation, have been explained to me to my satisfaction and I have conveyed my understanding of both to the Doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____/_____/_____
Patient or Authorized Person's Signature Date Office Staff Witness Initials

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *Please read carefully and check the box or boxes that apply. Please include the appropriate date and sign below if you understand and have no further questions. Otherwise, ask a team member for further explanation.*

The first day of my last menstrual cycle was on ____-____-____ (Date)

I have no reason to believe I would be pregnant, and to the best of my knowledge, I am not pregnant currently.

By my signature below, I am acknowledging that the doctor and/or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____/_____/_____
Patient or Authorized Person's Signature Date Office Staff Witness Initials

SYNAPSE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition, we must provide you with written notice concerning your rights to gain access to your health information and the potential circumstances under which, by law, or as **dictated by our office policy**, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Ranvir Sahota at (916) 625-6395. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

SYNAPSE CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued...

I have received a copy of Synapse Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the Doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name

Patient's Signature

Date

Office Staff Witness Signature

Date