SYNERGY PT
& ATHLETIC PERFORMANCE

16412 Jefferson Davis HWY
South Chesterfield, VA 23834
P: 804-520-7779 F: 866-463-3047

Please provide the following information. Please note: information you provide here is protected as confidential information

PATIENT INFORMATION: **DATE: _____**

Last Name: _____ First Name: _____ MI: _____ Gender: _____

Social Security: _____ Date of Birth: _____ Marital Status: _____

Address: _____ Apt #: _____ City: _____ State: ____ Zip: _____

Phone #: (Home) _____ (Mobile): _____ (Email): _____

Parent/Guardian *(if applicable)*: _____ Phone #: _____

EMERGENCY CONTACT:

Last Name: _____First Name: _____Relationship:_____ Phone #: _____

Last Name: _____First Name: _____Relationship:_____ Phone #: _____

INSURANCE INFORMATION:

Policy Holder Name: _____ Date of Birth: _____

Address *(if different than above address):*_____City: _____ State: ____ Zip: _____

Primary Insurance Company: _____ Member/Subscriber ID: _____

Secondary Insurance Company: _____ Member/ Subscriber ID: _____

Tertiary Insurance Company: _____ Member/ Subscriber ID: _____

WORKER'S COMPENSATION:

Case Manager: _____ Phone #:_____ Claims #:_____Date of Injury:_____

Job Title:_____Duties:_____

Employer: _____ Phone #:_____

Address: _____City: _____ State: _____ Zip: _____

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Please provide the following information. Please note: information you provide here is protected as confidential information

REASON FOR VISIT:

Primary Care Doctor: _____ Referring Doctor:_____

Body Part Being Treated: _____Date of Injury: _____ Date of Surgery *(if applicable)*: _____

Describe body part/injury & how it happened *(be as specific as possible)*: _____

_____

_____

MEDICAL HISTORY:

Alzheimer's/Dementia	YES	NO	History of Cancer	YES	NO
Heart Disease	YES	NO	Immunosuppression	YES	NO
Stroke	YES	NO	Obesity	YES	NO
Current Infection	YES	NO	Osteoarthritis	YES	NO
Diabetes Type 1/Type 2 (circle one)	YES	NO	Parkinson's Disease	YES	NO
Fibromyalgia	YES	NO	Rheumatoid Arthritis	YES	NO
Fractures	YES	NO	Traumatic Brain Injury	YES	NO
High Blood Pressure	YES	NO	Headaches/ Migraines	YES	NO
Seizures	YES	NO	Allergies	YES	NO
Arthritis	YES	NO	Other:		

If you answered yes to any of the above please elaborate and include any conditions for which you have received medical treatment: _____

_____

Please list any past Surgeries: _____

Please provide current medications *(if any)*: _____

_____

_____

PLEASE NOTE:

It is the client's responsibility to disclose their full medical history. Failure to do so jeopardizes your health and our ability to assist you in accomplishing your goals. Your signature below denotes that you have/ will disclose all of your past medical history and any future changes in such information.

Signature:_____ Date:_____

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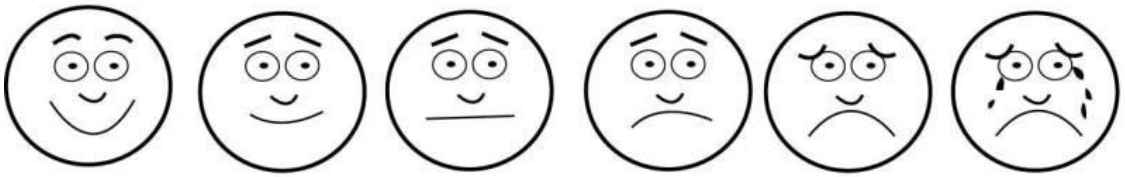
Please provide the following information. Please note: information you provide here is protected as confidential information

Are you in pain?



0 very happy, no pain | 1 - 2 hurts just a little bit | 3 - 4 hurts a little more | 5 - 6 hurts even more | 7 - 8 hurts a whole lot | 9 - 10 hurts as much as possible

AVERAGE PAIN INTENSITY:

Last 24 hours:	**No Pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Pain**
Past week:	**No Pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst Pain**

On the drawing below, Please darken or place and X on the area(s) where your pain in located.