

Client Information

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

DOB: _____

AGE: _____

SS#: _____

HOME PHONE: _____

CELL PHONE: _____

WORK PHONE: _____

EMAIL ADDRESS: _____

MARITAL STATUS: S M D W

CHILDREN: Y N HOW MANY: _____

OCCUPATION: _____

OCCUPATION ADDRESS: _____

CITY/STATE/ZIP: _____

WHO REFERRED YOU TO OHPC: _____

EMERGENCY CONTACT: _____

TELEPHONE NUMBER: _____



Waiver/Release of Liability/Informed Consent

In consideration of Synaptic Chiropractic Center, INC (herein "Synaptic") granting permission to enter and use its fitness facilities located at 4501 Hills and Dales Rd NW, Canton, OH 44708, as a client of Synaptic, I waive all claims against Synaptic, its officers, agents, employees, or related entities (collectively, Synaptic Parties) for damage or loss to my person and property that may be caused by any act, or failure to act, of any Parties from any and all claims, and I further agree to indemnify and hold harmless the Synaptic Parties from any and all claims, damages, or causes of action, including, but not limited too, personal injury, in connection with, or arising out of, my exercising in the facility, my participation in any diet or nutritional programs, my participation in any workout program or routine, whether sponsored by any of the Synaptic Parties or not, and any activities relating to my use of the fitness facility. I assume the risk of all dangerous conditions in and about the work-out facility and the equipment in the work-out facility, and I waive any and all specific notice of the existence of any such conditions. I agree to consult a medical physician before beginning or participating in any work-out routine or program or any nutritional program. I hereby certify that I have read the foregoing Facility Waiver, know and understand its contents, that I have signed the same as my free act and deed, and that I am a voluntary participant in the above-described recreation, fitness activity, and/or nutritional program.

Signed: _____ Date _____
 Witness: _____

Medical History:

Do you have or have you had any of the following (Check all that Apply):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fractures | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prosthesis | _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Psychiatric Care | _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever | _____ |

Medication/Nutritional Supplement Intake Form

Are you currently taking ANY medications (prescription or over-the-counter)?

Yes_____ No_____

If yes, please list all Medications you are currently taking:

Who is your family doctor: _____

Do you currently see any specialists (please list): _____

Are you currently taking ANY nutritional supplements (including multivitamins)?

Yes_____ No_____

If yes, please list all supplements you are currently taking:

Please list the conditions, or reasons, why you are currently taking medications and/or supplements:

Are the supplements you are now taking recommended by a health professional?

Yes_____ No_____

If you are not currently taking supplements, do you believe that with the educated recommendation of your health professional, they have the potential to help your overall health?

Yes _____ No_____ Possibly_____

Would you prefer that your health professional make nutritional supplement recommendations, if they believed it would help to relieve your symptoms?

Yes_____ No_____ Possibly_____

Are there specific nutritional supplements that you would like to know more about?

Yes _____ No_____ (if yes, list)

Authorization to Release Records to my Family Physician or Specialist

I _____ authorize Dr. Brandon Blood, DC, DAAPM and Synaptic Chiropractic Center, INC to release my records from the Synaptic to _____, my Family Physician as well as to _____, the Specialist that I have seen for my condition (if applicable).

Patient Name

Patient/Guardian Signature

Date

Synaptic Chiropractic Center, INC
4501 Hills and Dales Rd NW
Canton, OH 44708
(330) 479-9165 (Fax)

Authorization for Release of Medical Information

I _____ request and authorize _____ to release _____ records to Synaptic Chiropractic Center, INC to help them in determining my care.

Please Fax Records to: Dr. Brandon Blood, DC, DAAPM, FIAMA

Fax Number: (330) 479-9165

Patient Signature: _____ Date of Birth: _____

Social Security Number: _____

Financial Policy

I agree and understand that I am entering into a monthly 'membership-style' contract with Synaptic Chiropractic Center, INC (dba Ohio Human Performance Center). I understand, that regardless of how many times that I come to Synaptic Chiropractic Center in any given month, that my membership will be renewed as outlined in this agreement. I also understand that, for both my convenience and the convenience of Synaptic Chiropractic Center, INC to offer these services, my credit card/debit card will be set-up for auto-renew and the given card will be charged each month on the same day of my original registration.

Term Commitment

In consideration of the nature of the program that I am entering into, I realize that it will take time to accomplish my weight loss/personal health goals. For this reason, I understand that my commitment to this program needs to be a minimum of 6 months, also realizing that it may take longer than that depending on my current health status.

Signed: _____ Date: _____

Credit Card Type (please circle): Visa Mastercard AMEX Discover

Name on Credit Card: _____

Credit Card Number: _____

Expiration Date: _____

3-digit Security Code: _____

Billing Address: _____

By signing this form, I understand this policy and that the credit/debit card given will be automatically charged each month as outlined above.

Signed: _____ Date: _____

Cancellation Policy

I understand that by joining this program, I have made a minimum 6 month commitment to myself to reach my weight loss/personal health goals. I understand that if circumstances arise where I can no longer participate medically in this program, I can cancel my membership by written notice accompanied with medical documentation. My written notice must be submitted 14 days prior to my renewal date. I understand that if I cancel, and decide to rejoin at a later date, I will have to pay any applicable joining fees. I also understand that if I have any signed medical documentation that will prevent me from participating, I am also able to put my membership on hold without penalty or having to re-pay any joining fees.

Signed: _____ Date: _____

INITIAL CONSULTATION QUESTIONNAIRE
for Weight Management Members Only

What kind of food issues and weight problems do you have?

How much weight do you want to lose?

Please describe what types of diet/weight programs you have done in the past:

What did you like about what you have done before?

What did you dislike about it and what did not work?

If you could design your own program, what would be the most important elements in it?

What habits do you want to change?

What unhealthy or addictive food choices are you currently making?

Do you ever find yourself eating when not hungry?

Do you feel out of control with food sometimes?

Do you have binges? If yes, how often?

What do you do afterwards (e.g. fast, diet, exercise, vomit?)

Do you crave or binge on certain types of foods at, certain times of the day? If yes, please describe:

Why do you want to resolve these issues?

If these issues were resolved, how would you feel?

How do you feel about your body?

When do you feel satisfied with yourself (Are you ever satisfied with yourself?)

Have you engaged in an exercise program recently? If yes, please describe:

What type of physical activities do you enjoy doing? Please describe:

**If you were the weight you want to be and enjoyed a healthy body, how would you act differently?
How would your life feel to you? How would you feel to yourself?**

PAR-Q FORM

Please mark YES or No to the following

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their physician before they start becoming more physically active. Please complete this form as accurately and completely as possible.

Please mark YES or No to the following

YES NO

Has your doctor ever said that you have a heart condition and recommended only medically supervised physical activity? _____

Do you frequently have pains in your chest when you perform physical activity? _____

Have you had chest pain when you were not doing physical activity? _____

Have you had a stroke? _____

Do you lose your balance due to dizziness or do you ever lose consciousness? _____

Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (i.e. diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anorexia, bulimia, anemia, epilepsy, respiratory ailments, back problems, etc.)? _____

Are you pregnant now or have given birth within the last 6 months? _____

Do you have asthma or exercise induced asthma? _____

Do you have low blood sugar levels (hypoglycemia)? _____

Do you have diabetes? _____

Have you had a recent surgery? _____

If you have marked YES to any of the above, please elaborate below:

Do you take any medications, either prescription or non-prescription, on a regular basis? Yes/No
What is the medication for?

How does this medication affect your ability to exercise or achieve your fitness goals?

Please note: If your health changes such that you could then answer YES to any of the above questions, tell your trainer/coach. Ask whether you should change your physical activity plan.

I have read, understood, and completed the questionnaire. Any questions I had were answered to my full satisfaction.

Print Name: _____ Signature: _____

Date: _____

HEALTH STATUS QUESTIONNAIRE – RAND 36

Patient Name _____

Date _____

1. In general, would you say your health is:
(circle one number)

- Excellent 1
- Very Good 2
- Good 3
- Fair 4
- Poor 5

2. Compared to one year ago, how would you rate your health in general now?
(circle one number)

- Much better now than one year ago 1
- Somewhat better now than one year ago 2
- About the same 3
- Somewhat worse now than one year ago 4
- Much worse now than one year ago 5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.	1	2	3
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	1	2	3
5. Lifting or carrying groceries.	1	2	3
6. Climbing several flights of stairs.	1	2	3
7. Climbing one flight of stairs.	1	2	3
8. Bending, kneeling or stooping	1	2	3
9. Walking more than a mile.	1	2	3
10. Walking several blocks	1	2	3
11. Walking one block	1	2	3
12. Bathing or dressing yourself	1	2	3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
(circle one number on each line)

	Yes	No
13. Cut down the amount of time you spent on work or other activities.	1	2
14. Accomplished less than you would like.	1	2
15. Were limited in the kind of work or other activities.	1	2
16. Had difficulty performing the work or other activities. (for example, it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
(circle one number on each line)

	Yes	No
17. Cut down the amount of time you spent on work or other activities.	1	2
18. Accomplished less than you would like.	1	2
19. Didn't do work or other activities as carefully as usual.	1	2

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
(circle one number)

- Not at all 1
- Slightly 2
- Moderately 3
- Quite a bit 4
- Extremely 5

21. How much bodily pain have you had during the past 4 weeks?
(circle one number)

- None 1
- Very mild 2
- Mild 3
- Moderate 4
- Severe 5
- Very Severe 6

22. During the past 4 weeks how much did pain interfere with your normal work (including both work outside the home and housework)?
(circle one number)

- None at all 1
- A little bit 2
- Moderately 3
- Quite a bit 4
- Extremely 5

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . .

(circle one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities?
(like visiting with friends, relatives, etc.)

(circle one number)

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people.	1	2	3	4	5
34. I am as healthy as anybody I know.	1	2	3	4	5
35. I expect my health to get worse.	1	2	3	4	5
36. My health is excellent.	1	2	3	4	5

**EXAM FORM
TO BE COMPLETED BY DOCTOR/TRAINER**

Patient Name: _____

Age: _____

Height: _____

Weight: _____

Blood Pressure: _____

Pulse: _____

Target Heart Rate Zone: _____

Body-Mass-Index (BMI): _____

Body Fat %:

Tricep: _____

Ilium: _____

Abdomen: _____

Thigh: _____

Calf: _____

Circumference:

Abdomen: _____

Waist: _____

Thigh: _____

Calf: _____

Pain with ROM (Yes/No):

Cervical

_____ Flexion

_____ Extension

_____ Right Rotation

_____ Left Rotation

_____ Right Lateral Bending

_____ Left Lateral Bending

Lumbar

_____ Flexion

_____ Extension

_____ Right Rotation

_____ Left Rotation

_____ Right Lateral Bending

_____ Left Lateral Bending

Shoulder

R / L

_____ Flexion

_____ Extension

_____ Abduction

_____ Adduction

_____ Internal Rotation

_____ External Rotation

Hip

R / L

_____ Flexion

_____ Extension

_____ Abduction

_____ Adduction

_____ Internal Rotation

_____ External Rotation

Functional Squat Test: **Pass** **Fail**

Hamstring Flexibility: **Poor** **Decent** **Good** **Excellent**

Appley Scratch ROM: **Poor** **Decent** **Good** **Excellent**

Signed: _____

Nutritional Supplement Prescription

Patient Name: _____

Patient DOB: _____

Patient's Medications: _____

Supplement	Quantity/Dosage	Frequency	Duration
Multivitamin			
Fish Oil: Omega-3 Fatty Acids			
Magnesium			
Vitamin D			
CoQ10			
Chromium (Chromease)			
Joint Support Formula			
Probiotics			
Stress B Complex			
Carnitine			
Glutamine			
Arginine/Ornithine			
SP Cleanse Program			
Cleanse Program			
Whey Protein			

Doctor Signature: _____

Patient Signature: _____

Date: _____