AXIS CHIROPRACTIC

450 Alkyre Run Drive #120 • Westerville, Ohio 43082
Phone: 614-901-9695 • Fax: 614-901-9720

Welcome to our office! Please complete the following information:

PERSONAL HISTORY

Patient Name: _____

Email: _____

Address: _____

City: _____ State: OH Zip: _____

Phone #: (Home) _____ (Cell) _____ (Work) _____

Social Security #: _____ Drivers License #: _____ Sex: ◯ M ◯ F

Birth Date: _____ Marital Status: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ SEPARATED

Employer Name: _____ Ext: _____

Type of work: _____

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Business #: _____

Names/Ages of Children: _____

Emergency Contact: _____

Relationship: _____ Phone #: _____

RESPONSIBLE PARTY

Insurance Company Name: _____ Phone #: _____

Insured Person's Name: _____

Relationship: _____ Insured's Date of Birth: _____

Attorney Name: _____

CURRENT HEALTH CONDITION

Area(s) of Complaint: _____

Have you been previously treated for this condition? ◯ Y ◯ N Doctor: _____

Treatment: _____ Results: _____

Injury Date: _____ Injury Relation: ◯ JOB ◯ AUTO ◯ HOME ◯ OTHER _____

Do you wear a shoe lift? ◯ Y ◯ N Current Medications: _____

PAST HEALTH HISTORY

Please check any surgeries or operations: ◯ APPENDECTOMY ◯ TONSILLECTOMY ◯ GALL BLADDER

◯ HERNIA ◯ BACK SURGERY ◯ BROKEN BONES ☐ OTHER _____

List any major accidents or falls: _____

Hospitalization (other than above): _____

Have you ever seen a chiropractor before? ◯ Y ◯ N Doctor: _____

Date of Last Visit: _____ Any Other Health Conditions: _____

Below are lists of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ○ Pneumonia
- ○ Rheumatic Fever
- ○ Polio
- ○ Tuberculosis
- ○ Whooping Cough
- ○ Anemia
- ○ Mental Disorders
- ○ Eczema
- ○ Measles
- ○ Mumps
- ○ Small Pox
- ○ Chicken Pox
- ○ Diabetes
- ○ Cancer
- ○ Lumbago
- ○ Heart Disease
- ○ Thyroid
- ○ Influenza
- ○ Pleurisy
- ○ Arthritis
- ○ Epilepsy

INTAKE:

- ○ Coffee
- ○ Tea
- ○ Alcohol
- ☐ Cigarettes

Have you been tested HIV Positive?
○ Y ○ N

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 6 MONTHS:

MUSCULOSKELETAL

- ○ Low Back Pain
- ☐ Pain Between Shoulders
- ○ Neck Pain
- ○ Arm Pain
- ○ Joint Pain/Stiffness
- ○ Walking Problems
- ○ Difficult Chewing/Clicking Jaw
- ○ General Stiffness

NERVOUS SYSTEM

- ○ Nervous
- ○ Numbness
- ○ Paralysis
- ○ Dizziness
- ○ Forgetfulness
- ○ Depression
- ○ Fainting
- ○ Convulsions
- ○ Cold/Tingling Extremities
- ○ Stress

GENERAL

- ○ Fatigue ○ Allergies
- ○ Loss of Sleep
- ○ Fever ○ Headaches

C-V-R CODE

- ○ Chest Pain/Shortess of Breath
- ○ Stroke
- ○ Blood Pressure Problems
- ○ Irregular Heart Beat
- ○ Heart Problems
- ○ Lung Problems/Congestion
- ○ Varicose Veins
- ○ Ankle Swelling

EENT CODE

- ○ Vision Problems
- ○ Dental Problems
- ○ Sore Throat
- ○ Ear Aches
- ○ Hearing Difficulties
- ○ Stuffed Nose

GASTROINTESTINAL

- ○ Poor/Excessive Appetite
- ○ Excessive Thirst
- ○ Frequent Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Hemorrhoids
- ○ Liver Problems
- ○ Gall Bladder Problems
- ○ Weight Problems
- ○ Abdominal Cramps

GENITOURINARY

- ○ Bladder Trouble
- ○ Painful/Excessive Urination
- ○ Discolored Urine

MALE/FEMALE

- ○ Menstrual Irregularity
- ○ Menstrual Cramps
- ○ Vaginal Pain/Infection
- ○ Breast Pain/Lumps
- ○ Sexual Dysfunction
- ○ Other Problems:

_____

_____

FEMALES ONLY

When was your last period?_____

○ CANNOT REMEMBER ○ NO LONGER MENSTRUATE

Are you pregnant? ○ Y ○ N ○ NOT SURE

FAMILY HISTORY

The following members have the same or similar problems:

- ○ Father ○ Mother
- ○ Sister ○ Brother
- ○ Spouse ○ Child

AXIS CHIROPRACTIC

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my ultimate responsibility for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered to me will be immediately due.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid to the Doctor, for x-rays, is for examination purposes only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient is in the office. I also agree that I am responsible for all bills incurred at this office.

Patient Signature _____

I hereby designate Axis Chiropractic (hereafter referred to as "my doctor"), to the full extent permissible under the Employee Retirement Income Security Act of 1974 (ERISA) and as provided in 29 CFR2560-503-1(b)4 to act on my behalf to pursue claims and exercise all rights connected with my employee, health, or car benefit plan, with respect to any medical or health care expense(s) incurred as a result of the services I receive from the above named company. These rights include the right to act on my behalf with respect to initial determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies, all in connection with medical or other health care expense(s) as the result of the services I received from the doctor.

X Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

AXIS CHIROPRACTIC

FOR OFFICE USE ONLY

Analysis: _____

Diagnosis: _____

Patient Accepted: ○ Y ○ N ○ REFERRED

Doctor's Signature _____

AXIS CHIROPRACTIC

HEALTH CARE AUTHORIZATION

THE FOLLOWING AUTHORIZES AXIS CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Axis Chiropractic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related emails, messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Axis Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a Doctor or Physical Therapist in private, the Doctor or Therapist will provide a private room for these conversations.

By signing the following you are giving Axis Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

ACKNOWLEDGMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I, _____, understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health care information for directory purpose
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

_____ _____

Signature of Patient/or Guardian of Said Minor Date

RADIOGRAPH CONSENT

I,_____, do hereby give my consent to allow Axis Chiropractic and its representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

O I also hereby declare that to my knowledge that I am not pregnant _____ (please initial)

_____ _____

Signature of Patient/or Guardian of Said Minor Date

REQUEST FOR PATIENT MEDICAL RECORDS / X-RAYS

ATTENTION: Medical records

Fax #: _____

Date of Request: _____

Doctor / Hospital Name: _____

Phone Number of Doctor / Hospital: _____ Date of Service: _____

Print Patient Name: _____

Patient Date of Birth: _____ Social Security Number:_____

I hereby authorize the release of my records and/or x-rays and request that they be transferred to:

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