AXIS CHIROPRACTIC

Corrective Spine Care

PATIENT APPLICATION FORM

WELCOME and THANK YOU for applying as a patient in our clinic. We are a very unique team specializing in researched-based spinal and postural rehabilitation. These methods have enabled our patients to achieve their optimal health; even when many other systems have failed. Because of this specialized approach, we may not accept you as a patient until we are absolutely certain we know the cause of your condition, that we can perform the necessary tests to establish an optimal rehab program for you, and are completely confident we can help you recover your health. Please know if we do accept you as a patient, we will then make specific recommendations based upon our understanding that your health will become your TOP PRIORITY. Thank you again for applying as a patient in our clinic.

_____

Patient name

_____

Date Completed

VRC / PIP _____

Patient Information

Name: _____ (Age)_____ Gender: M F

Home Address: _____ Home Phone: ( )_____

City, State, Zip: _____ Work Phone: ( )_____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: ____ /____ /____ Marital Status: S M D W

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( )_____Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Was this caused by a specific type of injury: YES / NO If YES Explain:_____ Date:_____

Are you symptoms the result of: **Auto Injury**: Yes / No **Work Injury**: Yes / No Date:_____

If your symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

**** Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your symptoms. ****

When did these symptoms begin?_____/_____/_____Are they: q Constant q Intermittent q Activity-related

Are they getting worse? q Yes q No Do they interfere with: q Work q Sleep q Hobbies q Daily Routine

Explain:_____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? q Yes q No If yes, explain: _____

Have you experienced these symptoms before (if not accident/injury related)? q Yes q No

If yes, explain: _____

Have you been treated for this? q Yes q No When were you last treated?_____/_____/_____

What treatment was performed? _____

How did you respond? _____

Experience with Chiropractic

Have you seen a Chiropractor before? q Yes q No Who? _____

Reason for visit(s): _____

Did your previous chiropractor take 'before' and 'after' x-rays? q Yes q No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? q Yes q No Did they recommend a Home Health Care program? q Yes q No

If yes, what? _____ How long were you treated? _____ Last treatment: ____/____ /____

How did you respond? _____

Are you aware of any poor posture habits? q Yes q No Is there any history of spinal problems in your family? q Yes q No

If yes, explain: _____

_____

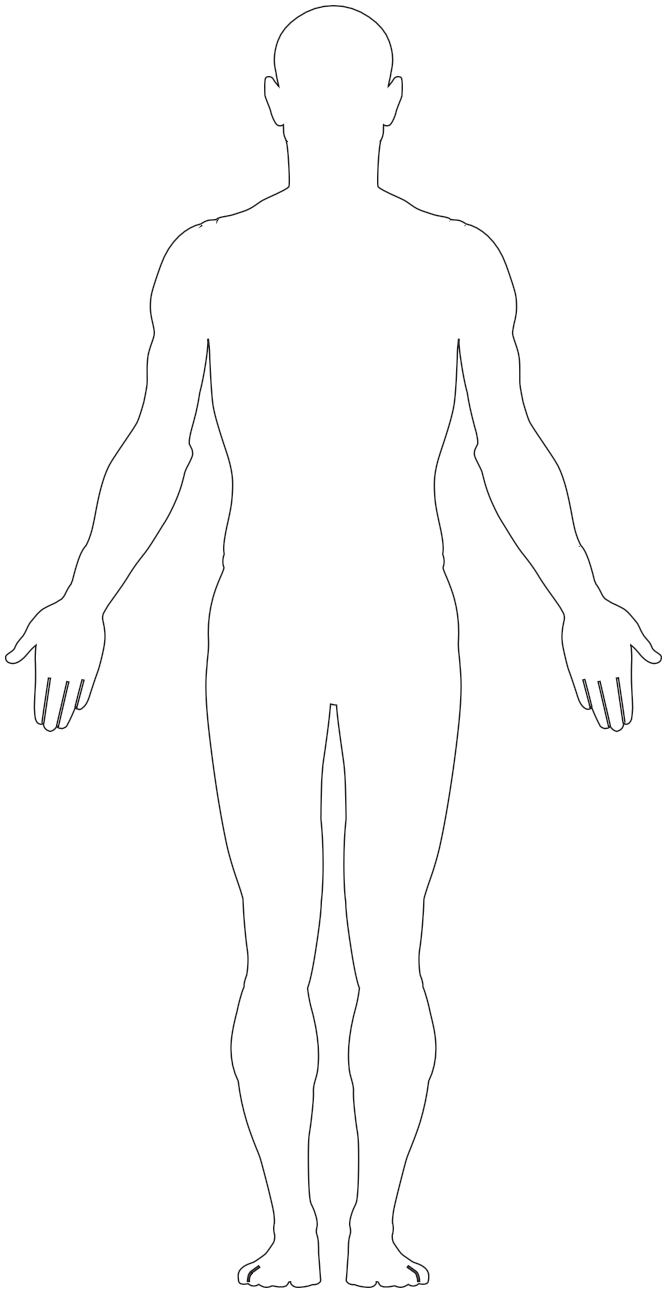
_____

_____

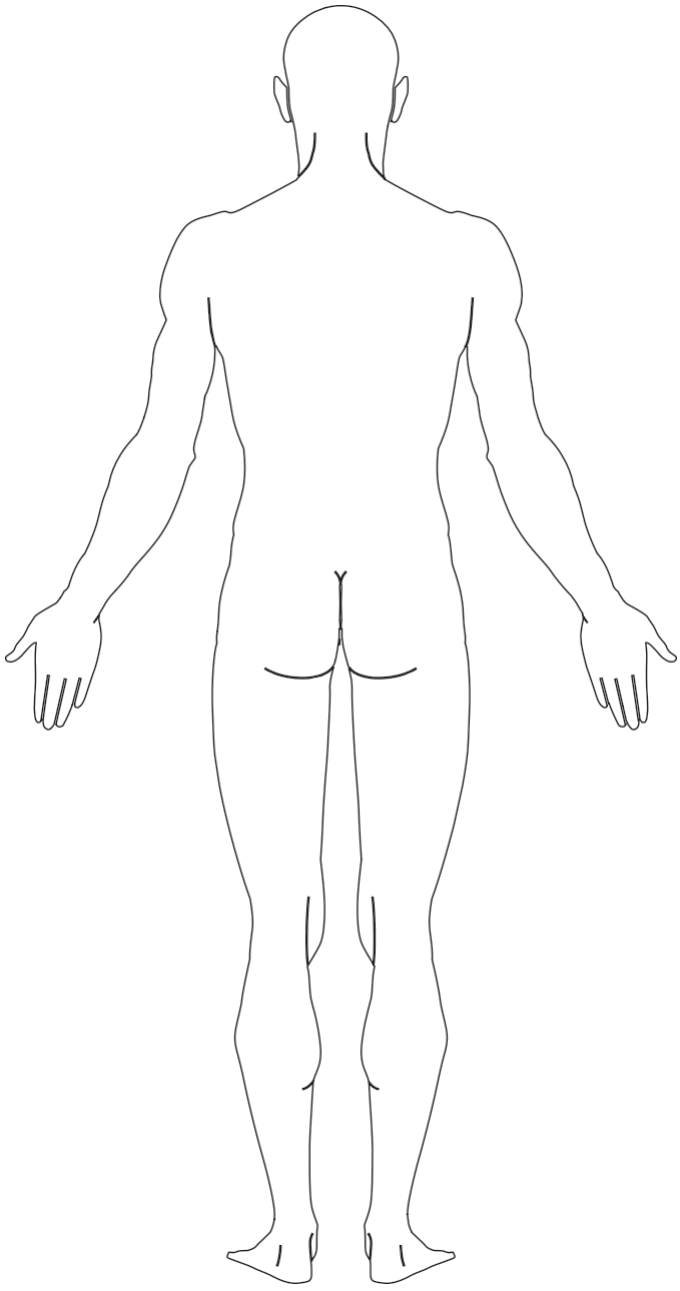
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	**S** = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	FF = STIFFNESS	O = OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

Health & Lifestyle

Do you exercise? q Yes q No How often?_____day(s) per week; Other: _____

What activities? q Walking q Running/Jogging q Weight Training q Cycling q Yoga q Pilates q Swimming q Other: _____

Do you smoke? q Yes q No How much? / How often? _____

Do you drink alcohol? q Yes q No How much? / How often? _____

Do you drink coffee? q Yes q No How much? / How often? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

If yes, please list: _____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your condition.

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past? If pain is NOW, please CIRCLE the % frequency, and the number severity.

Please indicate: (N) = Now, (P) = Past, next to all conditions you've experienced or both if applicable.

_____Headache Pain	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Hearing disturbances	_____Sinusitis
_____Neck Pain	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Dizziness	_____Allergies / Hay fever
_____Pain Shoulders/Arms/hands	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Visual disturbances	_____Recurrent colds / Flu
_____Numb-tingling: Arms/hands	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Coldness in hands	_____Low Energy / Fatigue
_____Weakness in the grip R / L			_____Thyroid conditions	_____TMJ-JAW: Pain / Clicking

Please explain: _____

_____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past? If pain is NOW, please CIRCLE the % frequency, and the number severity.

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

_____Heart Palpitations	_____Recurrent Lung Infections / Bronchitis		
_____Heart Murmurs	_____Asthma / Wheezing		
_____Tachycardia (racing heart beat)	_____Shortness Of Breath		
_____Heart Attacks / Angina	_____Chest or Rib Pain with breathing	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10

Please explain: _____

_____

_____

_____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

Health Conditions *continued...*

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Have you experienced any of these symptoms presently or in the past? If pain is NOW, please CIRCLE the % frequency, and the number severity.

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

_____Mid Back Pain	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Nausea	_____Diabetes
_____Pain in Ribs / Chest	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Ulcers / Gastritis	_____Hypoglycemia / Hyperglycemia
_____Pain shoulder blades	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Reflux	_____Indigestion / Heartburn

_____Tired / Irritable after eating or when not having eaten for a while

Please explain: _____

_____

_____

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the LUMBAR curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine, may result in many health conditions. Have you experienced any of these symptoms presently or in the past? If pain is NOW, please CIRCLE the % frequency, and the number severity.

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

_____Lower back pain / SI joint pain	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Frequent / difficulty urinating
_____Pain: hips / legs / feet	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Recurrent bladder infections
_____Numbness/tingling in legs/feet	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Menstrual cramps / irregularities
_____Muscle cramps in legs / feet	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____ Constipation / Diarrhea _____Coldness: legs / feet
_____Weakness: hips / knees / ankles	100% • 90-75% • 75-50% • 50-25% • 25-5%	1 2 3 4 5 6 7 8 9 10	_____Sexual dysfunction

Please Explain: _____

_____

OTHER

Please list any health conditions not mentioned: _____

_____

_____

_____

Please list any MEDICATIONS include name, dose, for what condition, and how long you've been taking it): _____

_____

_____

_____

Please list any SURGERIES (include type of surgery and date it was performed): _____

_____

_____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following ***(please indicate "Y" for You, and "O" for Other than you, or both if applicable)***:

____ Diabetes	____ Varicose Veins	____ Neurological Problems	____ Lung Disease
____ Rheumatic fever	____ Circulatory Problems	____ Stroke	____ Heart Murmur
____ High Blood Pressure	____ Heart Disease	____ Cancer	____ Osteoporosis
____ Kidney Disease	____ Paralysis	____ Migraine Headaches	____ Arthritis
____ Liver Disease	____ Metal Implants	____ Infectious Disease	____ Gall Bladder
____ Broken bones/fractures	____ Appendectomy	____ Tonsillectomy	____ Hernia
____ Pneumonia/Bronchitis	____ Polio	____ Tuberculosis	____ Anemia
____ Whooping Cough	____ Chicken Pox/Shingles	____ Mumps	____ Measles
____ Thyroid Problems	____ Small Pox	____ Influenza	____ Pleurisy
____ Blood Sugar Problems	____ Epilepsy/Seizures	____ Eczema/Psoriasis	____ Lumbago

____ Other: _____

_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle:_____/_____/_____

Patient's Signature_____ Date_____/_____/_____

Authorization of Care

I authorize and agree to allow the doctor and/or designated AXIS staff to take x-rays and work with my spine and/or joints of my body, through the use of spinal adjustments, rehabilitative exercises, and traction for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature_____Date _____ /_____/_____

Patient's Name Printed _____

If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature_____Date _____ /_____ /_____

In Case of Emergency

Name_____Relationship _____

Work Phone ( ) _____

Home Phone ( ) _____

Cell Phone ( ) _____

Insurance

We may accept assignment of PIP and MEDICARE insurance benefits ONLY. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits, such as PIP and MEDICARE, we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

ITEMIZED RECEIPTS, aka. "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does NOT participate with any major med insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? q Yes q No

Patient's Signature_____Date_____/_____/_____

Signature of Person Authorizing Care (if different from patient):

_____ Date_____/_____/_____

Relationship to Insured_____Date of Birth_____/_____/_____

Employer_____