AXIOM
CHIROPRACTIC

Whom may we thank for referring you to our office? _____

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____/_____/_____ Age: _____ ○ Male ○ Female

Address: _____ City: _____ State: _____ Zip: _____

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

E-mail Address: _____ Marital Status: ○ Single ○ Married Do you have insurance? ○ Yes ○ No

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____ Relationship: _____

HISTORY OF COMPLAINT

LIST YOUR HEALTH CONCERNS BELOW

((Please fill out to the best of your ability so we can go over them with you in the exam room))

Health Concerns: List according to severity	Severity of pain 1-10	When did this start?	Constant (C) Intermittent (I)	Chiropractic Assistant Notes (Office staff use only)
1.				
2.				
3.				
4.				
5.				

LIST RESTRICTED ACTIVITY	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL

Previous Chiropractor _____ How long were you seen?_____ Results? _____

What **relieves** your symptoms? _____

What makes your symptoms **feel worse**? _____

HEALTH GOALS: What are some **activities** or **things** in your life you want to be able to do, enjoy or experience but the above health concerns are preventing you? Be specific. The more the better. These are things we want to help you achieve in your life!

1. _____
2. _____
3. _____
4. _____

HR#: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ○ No ○ Yes **If yes,** how many times? _____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ○ No ○ Yes **If yes,** please state what type of treatment: _____, and who provided it? _____ How long ago? _____ What were the results. ○ Favorable ○ Unfavorable
Please explain: _____

P for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE	PROVIDED BY WHOM
Injuries			
Surgeries			
Childhood Diseases			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ○ No ○ Yes **If yes,** whom?
○ grandmother ○ grandfather ○ mother ○ father ○ sister(s) ○ brother(s) ○ son(s) ○ daughter(s)
Have they ever been treated for their condition? ○ No ○ Yes ○ I don't know

2. Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes: _____

SOCIAL HISTORY

1. Smoking: ○ cigars ○ pipe ○ cigarettes How often? ○ Daily ○ Weekends ○ Occasionally ○ Never
2. Alcoholic Beverage: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never
3. Recreational Drug use: ○ Daily ○ Weekends ○ Occasionally ○ Never

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

★★ **PLEASE FILL OUT THE FRONT PAGE WITH ANY CURRENT ISSUES MARKED ABOVE** ★★

HR#: _____

ACTIVITIES OF LIFE

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

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Lift Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sit to Stand	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Pet Care	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Getting Dressed	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Washing/Bathing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sweeping/Vacuuming	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Driving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

QUADRUPLE VISUAL ANALOGUE SCALE

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 =

INSTRUCTIONS: Please circle the number that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

headache neck low back

no pain — 0 1 (2) 3 (4) 5 6 7 8 (9) 10 — worst possible pain

##########

1. What is your pain RIGHT NOW?

no pain — 0 1 2 3 4 5 6 7 8 9 10 — worst possible pain

2. What is your TYPICAL or AVERAGE pain?

no pain — 0 1 2 3 4 5 6 7 8 9 10 — worst possible pain

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain — 0 1 2 3 4 5 6 7 8 9 10 — worst possible pain

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

no pain — 0 1 2 3 4 5 6 7 8 9 10 — worst possible pain

What percentage of your awake hours is your pain at its worst? _____%

HR#: _____

AXIOM 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 **P**ersonal **H**ealth **I**nformation. 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. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. 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 or your emergency contact.
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, texts, emails, and appointment reminders - **we may call your home, leave messages and texts** regarding a missed appointment or apprize 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.
12. Photography- Photos and videos taken of you while in the office are able to be used by Axiom Chiropractic for marketing and educational purposes.

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 health records at no charge, and when timely notice is provided (72 hours). **X-rays** are original records. However, you may request a copy of your x-rays, but you will be responsible for this cost which is $10.

COMPLAINTS:

If you wish to make a formal complaint about how we handle or handled your health information, please call Dr. Landon Staley at (435)-233-6075. 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

AXIOM CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

☐ 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 have received a copy of Axiom Chiropractic Patient Privacy Notice. 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. At this time, I do not have any questions regarding my rights or any of the information I have received.

INFORMED CONSENT

REGARDING: Payments, Claims and Finances:

☐ I hereby authorize payment to be made directly to Axiom Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Axiom Chiropractic for any and all services I receive at this office.

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 risks are most often very minimal, 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 Axiom Chiropractic 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.

_____ _____/_____/_____

(PRINT) Patients Name **Date of Birth**

_____ _____/_____/_____

(SIGN) Patient's or Authorized Person's Signature **Date**

_____ _____/_____/_____

Witness Signature **Date**

AXIOM CHIROPRACTIC