



## REGISTRATION INFORMATION

DATE: \_\_\_\_\_ PATIENT ACCOUNT#: \_\_\_\_\_

PATIENT: \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE INITIAL

RESPONSIBLE PARTY (IF MINOR): \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

SINGLE MARRIED WIDOWED SEPARATED DIVORCED

AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

OCCUPATION: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ MEDICAL DOCTORS NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ BUSINESS ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?

NAME RELATION TO YOU PHONE NUMBER

WHO REFERRED YOU? \_\_\_\_\_

I AUTHORIZE THE RELEASE NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT ON ANY CLAIM. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OR FACSIMILE CAN BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE OR OTHER OUTSIDE SOURCE. I HEREBY AUTHORIZE DR. CHAMBERS TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY) DATE



PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

REASON FOR TODAY'S VISIT:  EMERGENCY  NEW INJURY  OLD INJURY  CHRONIC PAIN

ARE YOU IN PAIN?  YES  NO

RATE YOUR PAIN WITH THE FOLLOWING SCALE:

	(NO PAIN)					(UNBEARABLE)				
	1	2	3	4	5	6	7	8	9	10
NECK										
MIDDLE BACK PAIN										
LOWER BACK PAIN										
OTHER: _____										

DID YOUR INJURY OCCUR DURING:  WORK  SPORTS/PLAY  AUTO ACCIDENT  DAILY ROUTINE/ACTIVITY?

IF SO, HOW? \_\_\_\_\_

IS YOUR CONDITION GETTING WORSE?  YES  NO  CONSTANT  COMES AND GOES

IS YOUR CONDITION INTERFERING WITH YOUR:  WORK  SLEEP  DAILY ROUTINE?

IF SO, HOW? \_\_\_\_\_

HAS THIS OR SOMETHING SIMILAR HAPPENED IN THE PAST?  YES  NO

EXPLAIN: \_\_\_\_\_

WHAT MAKES THE PAIN BETTER? \_\_\_\_\_

WHAT MAKES THE PAIN WORSE? \_\_\_\_\_

DOES THE PAIN RADIATE OR TRAVEL? EXPLAIN: \_\_\_\_\_

HAVE YOU BEEN TREATED BY A MEDICAL PHYSICIAN

FOR THIS PAIN?  YES  NO

IF SO, WHERE? \_\_\_\_\_

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR?

YES  NO

CLINIC/DOCTORS NAME: \_\_\_\_\_

HOW LONG AGO? \_\_\_\_\_

ARE YOU TAKING ANY MEDICATION?  YES  NO

IF YES PLEASE LIST MEDICATION: \_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD ANY DISEASES, MEDICAL CONDITIONS, SURGERIES OR PROCEDURES?

PLEASE LIST THEM: \_\_\_\_\_

*Please tell us who referred you to our office so that we may thank them:* \_\_\_\_\_



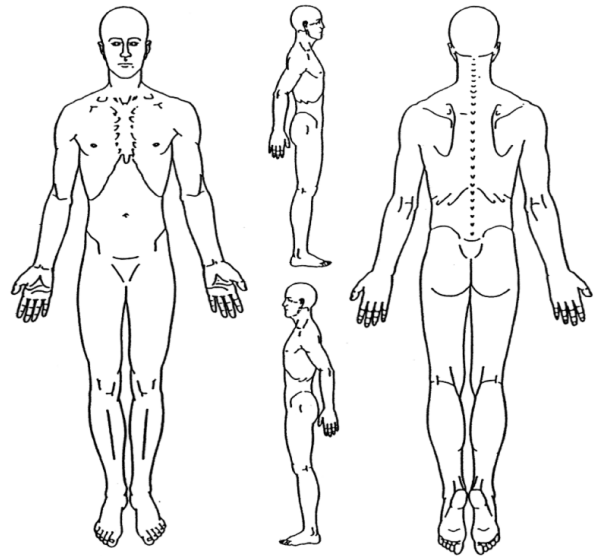
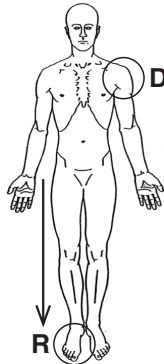
PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**USING THE ADJACENT BODY CHART,  
PLEASE CIRCLE ALL AFFECTED AREAS:**

CIRCLE THE SYMBOLS TO BEST DESCRIBE THE TYPE OF PAIN:

- D = DULL ACHE**      **N = NUMBNESS**      **B = BURNING**
- R = RADIATING**      **T = TINGLING**      **S = SHARP**
- (PAIN THAT TRAVELS)

**EXAMPLE:**  
RADIATING PAIN BEGINNING  
IN THE LOW BACK AND GOING  
DOWN TO THE RIGHT FOOT.



FAMILY HEALTH HISTORY: \_\_\_\_\_

DO YOU TAKE SUPPLEMENTS OR VITAMINS?  YES  NO

IF YES, WHICH SUPPLEMENTS ARE YOU TAKING? \_\_\_\_\_

DO YOU EXERCISE?  YES \_\_\_\_\_ HRS/WEEK  NO

DO YOU SMOKE?  YES  NO HOW MUCH? \_\_\_\_\_ HOW MANY YEARS? \_\_\_\_\_

DO YOU DRINK?  YES  NO HOW MUCH? \_\_\_\_\_ HOW MANY YEARS? \_\_\_\_\_

ARE YOU WEARING:  SHOE LIFTS  ARCH SUPPORTS  INNER SOLES?

ARE YOU DIETING?  YES  NO SINCE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ WHICH DIET ARE YOU USING: \_\_\_\_\_

**FOR WOMEN:** ARE YOU TAKING BIRTH CONTROL?  YES  NO

ARE YOU NURSING?  YES  NO ARE YOU PREGNANT?  YES  NO IF YES, HOW MANY WEEKS? \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ADULT PATIENT  PARENT OR GUARDIAN  SPOUSE



OCCASIONAL  
FREQUENT

**GENERAL**

- ALLERGY (LIST BELOW)\*
- CONVULSIONS
- DIZZINESS OR FAINTING
- HEADACHE
- NEURALGIA
- NUMBNESS

**MUSCLE**

- ARTHRITIS
- BURSITIS
- FOOT TROUBLE
- LOW BACK PAIN OR STIFFNESS
- PAIN BETWEEN SHOULDERS
- SCIATICA
- SWOLLEN JOINTS

**PAIN, NUMBNESS OR CRAMPS**

- SHOULDERS
- ARMS
- ELBOWS
- HANDS/WRISTS
- HIPS
- KNEES
- FEET/ANKLES

**GASTRO-INTESTINAL**

- COLON TROUBLE
- CONSTIPATION
- DIARRHEA
- DIFFICULTY DIGESTING
- GALL BLADDER TROUBLE
- HEMORRHOIDS
- LIVER TROUBLE
- PAIN OVER STOMACH

**EYES, EARS, NOSE & THROAT**

- ASTHMA
- COLDS
- DEAFNESS
- EARACHE
- EAR DISCHARGE
- EAR NOISE
- EYE PAIN
- NASAL OBSTRUCTION
- SINUS INFECTION

**CARDIO-VASCULAR**

- HARDENING OF THE ARTERIES
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- PAIN OVER HEART
- POOR CIRCULATION
- RAPID HEART BEAT
- SWELLING OF ANKLES

**RESPIRATORY**

- CHEST PAIN
- CHRONIC COUGH
- DIFFICULT BREATHING
- SPITTING UP BLOOD
- SPITTING UP PHLEGM
- WHEEZING

**SKIN**

- BRUISE EASILY
- DRYNESS
- SKIN ERUPTIONS (RASH)
- VARICOSE VEINS

**GENITO-URINARY**

- BED-WETTING
- BLOOD IN URINE
- FREQUENT URINATION
- KIDNEY INFECTION OR STONES
- PAINFUL URINATION
- PROSTATE TROUBLE
- PUS IN URINE

**FOR WOMEN ONLY**

- CRAMPS OR BACKACHE
- EXCESSIVE MENSTRUAL FLOW
- HOT FLASHES
- IRREGULAR CYCLE
- LUMPS IN BREAST
- MENOPAUSAL SYMPTOMS
- PAINFUL MENSTRUATION
- VAGINAL DISCHARGE

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ADULT PATIENT     PARENT OR GUARDIAN     SPOUSE





## OFFICE POLICY

The following is an example of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue, regaining and maintaining your health. We will be happy to answer any question regarding our policies, your account or insurance coverage.

**NO CHARGE CONSULTATION:** We feel the patient's health needs are first, therefore Axis Chiropractic and Wellness will do a special "no charge" consultation with anyone interested in finding out if chiropractic care can help them with their individual health problems.

**PATIENT PAYMENT POLICY:** Payment is due at time of service. This helps keep our overhead lower allowing us to reduce cost to you. We accept payments in the form of check, debit, MasterCard, Visa, and cash. A 10% interest charge will be applied to all account balances over 60 days.

**OFFICE HOURS:** Patients are seen by appointment only.

**MONDAY—FRIDAY 9 A.M.—6 P.M.**

**SATURDAY 9 A.M.—12 P.M.**

**EMERGENCY OR AFTER HOUR CALLS:** In case of emergency you may contact our office for a special appointment any time during regular office hours. If you, a friend, or family member required after hours or weekend assistance, you may call the clinic at 816-246-5300.

**MISSED APPOINTMENTS:** To better serve our patients, we ask that you call if you are unable to make your appointment, or if you are going to be late. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us to help others.

**QUESTIONS AND ANSWERS:** Your questions about any aspect of your care or account are invited. Please feel free to ask the doctor or any available staff member. We will make every effort to answer your inquiries.

I understand that no guarantee or warranty has been made to me that results will be to my complete satisfaction.

I have read the above policies and will honor them, as well as, understand and consent to treat.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_