229 NW BLUE PKWY, SUITE C • LEE'S SUMMIT, MO 64063 • 816-246-5300

axis chiropractic + wellness

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

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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)
NECK	1	2	3	4	5	6	7	8	9	10
MIDDLE BACK PAIN	1	2	3	4	5	6	7	8	9	10
LOWER BACK PAIN	1	2	3	4	5	6	7	8	9	10
OTHER:_____	1	2	3	4	5	6	7	8	9	10

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:*_____

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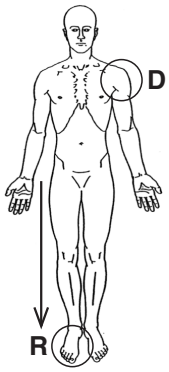
PATIENT NAME:_____ DATE:_____

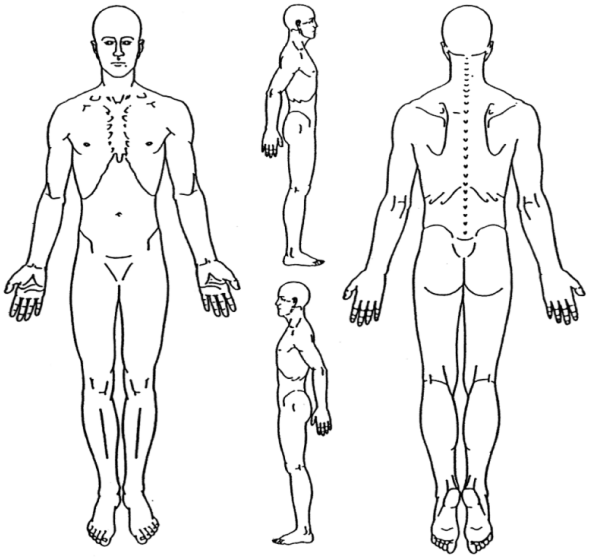
USING THE ADJACENT BODY CHART, PLEASE CIRCLE ALL AFFECTED AREAS:

CIRCLE THE SYMBOLS TO BEST DESCRIBE THE TYPE OF PAIN:

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

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

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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 changes 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

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INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, art, and philosophy which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral "subluxation". This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method or correction is achieved by specific gentle adjustments of the spine with the aide of a handheld adjusting instrument. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to: muscle or ligament injury, nerve injury, vascular injury, and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

PRINT NAME	SIGNATURE	DATE

I,_____ being the parent or legal guardian of _____Have fully understand the above informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her 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:_____

SIGNATURE OF PATIENT	DATE

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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:_____