# Axiom Health – Patient Intake

*– Please Fill In **COMPLETELY & LEGIBLY** –*

**Patient Demographics:**

Last Name: _____ First Name: _____ MI: _____ Sex: M F

DOB: ____ / ____ / _____ Age: ____ SSN: _____

Weight: _____ Height: _____ Name Suffix: ____

Marital Status: Single Married Separated Divorced Widowed Employment Status: _____

Address Line 1: _____ Address Line 2: _____

City: _____ Zip: _____

******Check Preferred Phone*** ☐ Work Phone: (_____) - _____ - _____ Ext: _____

☐ Home Phone: (_____) - _____ - _____ ☐ Cell Phone: (_____) - _____ - _____ Email: _____

**Employment Information:**

Employer Name: _____ Employer Phone: (_____) - _____ - _____

Address Line 1: _____ Address Line 2: _____

Employer City: _____ Zip: _____

**Emergency Contact:**

Contact Name: _____ Relationship to Patient: _____

Address Line 1: _____ Address Line 2: _____

City: _____ Zip: _____ ☐ Home ☐ Cell Ph: (_____) - _____ - _____

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**Primary Insurance:**

Insurance Name: _____

Last Name: _____ First Name: _____ MI: ____

Patient Relationship To Primary Insured: Self Spouse Child Other Relationship

Subscriber ID: _____ Group No: _____ Plan Name: _____

Insured Authorization: Yes / No Deductible: _____ Visit Co-payment: _____

**Secondary Insurance:**

Insurance Name: _____

Last Name: _____ First Name: _____ MI: ____

Patient Relationship To Secondary Insured: Self Spouse Child Other Relationship

Subscriber ID: _____ Group No: _____ Plan Name: _____

Insured Authorization: Yes / No Deductible: _____ Visit Co-payment: _____

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**Current Health Condition:**

Date of Injury: ____ / ____ / _____

**Describe how your problem began: _____**

_____

**Describe any additional areas of problem: _____**

**What causes you difficulty**: ____ Standing ____ Sitting ____ Lying Down ____ Other: _____

Walking: ____ Minimal ____ Moderate ____ Extended Riding (in auto): ____ Minimal ____ Moderate ____Extended

Twisting or Turning: ____ Light ____ Moderate ____ Heavy ____ Repetitive

Lifting: ____ Light ____ Moderate ____ Heavy ____ Repetitive ____ Rising to walk after sitting ____ Coughing & Sneezing

***See Other Side →***

**Have you seen another doctor for this problem?** Y N Type of Treatment: _____

**Has this happened before?** Y N When: _____

**Is your condition:** ____ Injury at work ____ Auto Accident ____ Fall ____ Home Injury

**Do you take any medication(s)?** ____Nerve Pills ____ Pain Killers ____ Blood Pressure ____ Insulin ____ Other

**Please check all of the following that apply to you:** ☐ None Apply

| No | Yes | Condition | No | Yes | Condition |
|---|---|---|---|---|---|
| ☐ | ☐ | Recent Infection | ☐ | ☐ | Abnormal Weight ☐ Gain ☐ Loss |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Epilepsy/Seizures |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Visual Disturbances |
| ☐ | ☐ | Dizziness/Fainting | ☐ | ☐ | Low/Mid Back Pain |
| ☐ | ☐ | Numbness in Groin/Buttocks | ☐ | ☐ | Neck Pain |
| ☐ | ☐ | Cancer/Tumor | ☐ | ☐ | Arthritis |
| ☐ | ☐ | Osteoporosis | ☐ | ☐ | Prostrate Problems |
| ☐ | ☐ | Recent Trauma | ☐ | ☐ | Surgeries/ Medications: _____ |
| ☐ | ☐ | Other: _____ | | | _____ |

**Please tell us in your own words about any other condition or injury you have had previously:** _____

_____

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I understand that, as with any form of exercise, muscle testing and rehabilitation procedures carry with them a small inherent risk of injury, which includes but is not limited to minor strains of the specific muscles being used during testing or rehabilitation. Additionally, as in the case with most health care interventions, there is a certain (albeit rare) inherent risk of complication associated with physical examination, physiotherapeutic and spinal manipulation procedures. These complications include but are not limited to muscle strains, dislocations, skin irritations, costrovertebral sprains, electrical shock, fractures, disc trauma, minor burns, and stroke. I understand my doctor will not be able to anticipate all potential complications, but elect to rely on his/her clinical expertise and judgment to determine reasonable courses of clinical action, based upon known facts, which are considered to be in my best interest. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and hereby consent to voluntarily participate in a physical examination, physiotherapeutic, manipulative, muscle testing/rehabilitation, and/or other medical management procedures as deemed appropriate by my doctor. If at any time I decide that I am unwilling to engage in these procedures, I reserve the right to inform my doctor of such and not participate in these forms of evaluation or treatment.

As the undersigned I certify that I (or my dependant) have insurance coverage with _____ and assign directly to Dr. Patel all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

**Chiropractors Right:** We do our best to respect your time. However, special circumstances may arise. Dr. Rudy Patel has the right to reschedule appointments.

*****<u>Missed or Canceled Appointment Fees</u>*****

Please give us a 24-hour cancellation notice. We will charge an office visit if we do not receive such notice.

**Less than 24 hr notice (This includes illness or of self or family member) = $20 fee**

**No notice / no show = $40 fee**

I understand that the following fees will be incurred due to missed or cancelled appointments that are les than 24 hours from scheduled appointment time --regardless of the reason. Please initial _____.

_____ _____

Patient Signature Date