Axelson
CHIROPRACTIC & REHAB

WELCOME SHEET

PATIENT INFO

Patient Name _____
What Do You Prefer To Be Called? _____
Address _____
City/State/Zip _____
Home Phone (_____) _____
Cell Phone (_____) _____
Work Phone (_____) _____ Ext _____
Email: _____
Birthday: _____ Sex: ☐Male ☐Female
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated
☐Child ☐Widowed SS# _____
Referred By: ☐Print Ad ☐Internet ☐Website ☐Phonebook
☐Attorney ☐Doctor ☐Event _____
☐Friend/Family _____
☐Other _____

INSURANCE INFO

Primary Ins Co _____
Name of Insured _____
Insured's Relationship to Patient: ☐Self
☐Spouse ☐Parent ☐Child ☐Other
Insured's Birthday _____
Insured's Employer _____
Secondary Ins Co _____

SOCIAL HISTORY

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Student ☐Homemaker ☐Unemployed
Employer / School _____
Occupation _____ How Long? _____
What Do You Do Most of the Day at Work?
☐Sit ☐Stand ☐Light Labor ☐Heavy Labor ☐Other _____
Check Any of the Following in Which You Participate in Regularly:
☐Gardening ☐Bicycling ☐Swimming ☐Running ☐Weight Lifting
☐Aerobics/Cardio ☐Golf ☐Other _____
How Often Do You Participate? ☐2-3x's/Week ☐1x/Week ☐1-2x's/Month ☐Other _____
How much sleep do you get per night? ☐ 5 or Less ☐ 6-8 ☐ 8-10 ☐ 10 or More
Rate your sleep: No/Poor Sleep 0 1 2 3 4 5 6 7 8 9 10 Wake-up Fully Rested
List your major Stressors: _____
What are your Health Goals? _____

APPOINTMENT REMINDER

Would you like to receive appointment reminders? ☐ Yes (Circle one): Email / Text ☐ No
Email _____
Cell Phone # _____ Cell Phone Provider: AT&T/Verizon/Sprint/US Cellular/_____
When would you like reminder sent? (Circle one): 30 min / 45 min / 1 hr / 2 hrs / 4 hrs / 1 day / 2 days prior

REASON FOR VISIT

Reason for today's visit: Primary Complaint _____

Other Complaints _____

When did condition begin? _____ The discomfort is: □ getting worse □ constant □ comes & goes

Describe the discomfort: □ Sharp □ Shooting □ Aching □ Throbbing □ Burning □ Stiff □ Other _____

Does it interfere with Daily Activities: □ Sleep □ Walking/Running □ Sitting □ Standing □ Lifting □ Work □ Social Activities □ Personal Care □ Other _____

Please rate your discomfort at its worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Please rate your discomfort at its best: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Have you had this or a similar condition in the past? Y / N Explain _____

What treatment have you already received for your condition?

□ None □ Medication □ Surgery □ Physical Therapy □ Chiropractic □ Other _____

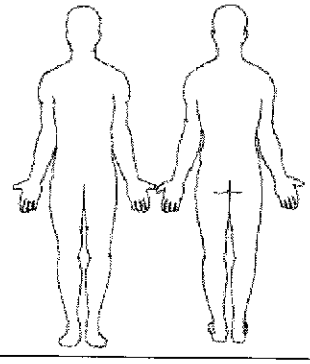
Were you satisfied with the results of your treatment? Y / N Explain _____

DESCRIBE THE DISCOMFORT

Please mark the diagram below by placing the appropriate symbol at the site of discomfort.

Symptom:	Symbol:
Numbness	NNN
Pins & Needles	PPP
Burning	BBB
Aching	AAA
Stabbing	SSS

Circle any other area not represented by a symbol.



HEALTH HISTORY

Do you have or have you had any of the following: □ Heart Attack/Stroke □ Pacemaker □ Heart Surgery
□ High/Low BP □ Difficulty Breathing □ Alcohol/Drug Abuse □ Diabetes □ Cancer
□ Arthritis □ Seizures/Fainting □ Artificial Joints □ HIV/AIDS □ Psychiatric Problems

Other serious medical conditions not listed above _____

List any surgeries (& dates) not listed above _____

Do you have any scars from surgeries/procedures? Y / N Where? _____

Do you wear: □ Heel Lifts □Orthotics □Inner Soles □ Arch Supports □ Other _____

List any allergies or skin sensitivities _____

Are you on any special diet? Y / N (Explain) _____

Who is your Medical Doctor? _____ Phone _____

IN CASE OF EMERGENCY

In case of emergency, whom should we contact? _____

Relationship: _____ Phone _____

* I authorize the staff to perform any necessary services needed during diagnosis & treatment.
* I authorize the provider to release any information required to process insurance claims.
* I acknowledge that this form was completed correctly to the best of my knowledge.
* I understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature _____ Date _____

Axelson
CHIROPRACTIC & REHAB

GENERAL RELEASE OF MEDICAL RECORDS

Patient's Name (printed) _____ **DOB:** _____

I hereby request and authorize: _____

Phone: _____ Fax: _____

to disclose my protected health information as indicated below:

Description of information to be disclosed*

_____ X-Ray Images/Reports _____ MRI Images/Reports

_____ Most Recent Notes _____ Most Recent Bloodwork

_____ OTHER _____

***Please send the most recent record unless otherwise specified**

A photocopy of this authorization will be accepted with the same authority as the original.

Reason for requested use or disclosure: continuance of care

This information is to be disclosed to: Axelson Chiropractic & Rehab
Address: 901 Newman Road
New Bern, NC 28562
Phone: 252-633-3334
Fax: 252-637-4483

TO BE READ AND SIGNED BY PATIENT

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c. The practice will not determine treatment or payment based on my signing this authorization.
d. No one has pressured me to sign this authorization.
e. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
f. I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.
g. I have right to request a copy of this authorization.

Patient's Signature: _____ **Date** _____

***This authorization shall be in force and effect until one year from date signed**

Axelson
CHIROPRACTIC & REHAB

901 Newman Road
New Bern, NC 28562
252-633-3334

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information (PHI)

Axelson Chiropractic may use or may disclose my PHI to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. _____ Patient Initials

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

I have received a copy of the Notice of Patient Privacy Policy. _____ Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your PHI. This office may or may not agree to restrict the use or disclosure of your PHI. If we agree to your request, the restriction will be binding with this office. Use or disclosure of PHI in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment

Axelson Chiropractic has private treatment rooms and an open therapy room. I consent to treatment & authorize the staff to perform any necessary services needed during diagnosis and treatment. _____ Patient Initials

I understand that I am required to make payment for all services rendered at the time of visit (whether covered or non-covered by insurance) and I am ultimately responsible for my account. _____ Patient Initials

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. This must be done in writing. Any use or disclosure that had occurred prior to the date on which your revocation of consent is received will not be affected.

Authorized Disclosure of PHI

I authorize the following person(s) to access my PHI (please list their name and their relationship to you):

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

Name _____ Relationship to patient _____

*This authorization will be valid for five years from the date signed unless revoked in writing or when a new authorization form is completed and signed. At that time, the updated authorization will replace this one.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Date of Birth

_____ _____
Witness Signature Date