Axness Integrative Medicine
GET A.I.M ON YOUR PAIN℠

Patient Name_____ Date: _____

DOB:_____ ☐ Male ☐ Female Email:_____

SS #/SIN_____ Home phone_____ Cell Phone _____

Reminder phone call preference: ☐Call to home phone ☐Call to cell phone ☐Text to cell phone

Check appropriate Box**:** ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Address _____City _____State_____ Zip_____

Employer Name:_____ Occupation:_____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____
Parent or Guardian Date

Currently pregnant? ☐Yes ☐No If yes, due date_____

Responsible Party

Name of The Person responsible for this account _____Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured_____ Relationship to patient _____

Birthdate_____ Name of Employer_____ Work Phone _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **AIM - Axness Integrative Medicine PLLC** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

□ **I have read and understand the "Patient Rights & Responsibilities" form**

□ **I have read and understand the "HIPPA Privacy Policy" form**

Signed this _____ day of _____, 20 _____. X _____
(patient signature)

X_____ X _____
(signature of Guardian, if applicable) (please print patient name)

Health History

Chief Complaint: _____

History of Present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: achy, burning, shar with motion, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(How did it start?)

Associated Signs/Symptoms _____
(What other associated problems have you been having?)

Modifying Factors _____
(What makes the pain/problem worse or better? Have you had previous episodes?

Past Medical History:

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO	YES	Anemia	NO	YES	Back Trouble	NO	YES	Hepatitis	NO	YES
Mumps	NO	YES	Ulcer	NO	YES	High Blood Pressure	NO	YES	Bladder Infection	NO	YES
Chicken Pox	NO	YES	Epilepsy	NO	YES	Low Blood Pressure	NO	YES	Bleeding Tendency	NO	YES
Whooping Cough	NO	YES	Stroke	NO	YES	Hemorrhoids	NO	YES	Migraine Headaches	NO	YES
Scarlet Fever	NO	YES	Bronchitis...	NO	YES	Kidney Disease	NO	YES	Date of last Chest X-ray		
Diphtheria	NO	YES	Diabetes	NO	YES	Thyroid Disease	NO	YES	Blood or Plasm.....	NO	YES
Small pox	NO	YES	Cancer	NO	YES	Hive of Eczema	NO	YES	Transfusion.....	NO	YES
Pneumonia	NO	YES	Polio	NO	YES	AIDS & HIV	NO	YES	Any Other Disease.....	NO	YES
Rheumatic Fever	NO	YES	Glaucoma...	NO	YES	Infectious Mono	NO	YES	(Please List)		
Arthritis	NO	YES	Hernia	NO	YES	Tuberculosis	NO	YES			
Venereal Disease	NO	YES	Asthma	NO	YES	Mitral Valve Prolepses...	NO	YES			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication: (include nonprescription)

_____

_____

Any Known Allergies: _____

(Medications, Latex, Foods, etc.)

Have you ever taken Fen-Phen/Redux? □ yes □ no

Are you taking any medications (prescription or over the counter) for acid indigestion?

□ yes □ no if yes, what type: _____

Patient Social History:

Marital Status	Single: _____	Married: _____	Separated: _____	Divorced: _____	Widowed: _____
Use of Alcohol	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Tobacco	Never: _____	Rarely: _____	Moderate: _____	Daily: _____	
Use of Drugs	Never: _____	Type/Frequency: _____			
Excessive Exposure at home or work to:	Fumes: _____	Dust: _____	Solvents: _____	Airborne Particles: _____	Noise: _____

Over ➡

Family Medical History:

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1	2	3	4	5
Stuffy Nose	1	2	3	4	5
Hay Fever	1	2	3	4	5
Sore Throat	1	2	3	4	5
Chronic Cough	1	2	3	4	5
Chest Congestion	1	2	3	4	5
Frequent Sneezing	1	2	3	4	5
Itchy/Watery Eyes	1	2	3	4	5
Drainage	1	2	3	4	5
Earache or Ear Infection	1	2	3	4	5
Itching	1	2	3	4	5
Hoarseness	1	2	3	4	5
Shortness of Breath	1	2	3	4	5
Wheezing	1	2	3	4	5

Neurological

Headaches	1	2	3	4	5
Migraines	1	2	3	4	5
Dizziness	1	2	3	4	5
Numbness	1	2	3	4	5
Tingling	1	2	3	4	5
Pins/Needles in hands or feet	1	2	3	4	5

Muscular/Skeletal

Muscle Aches	1	2	3	4	5
Fibromyalgia	1	2	3	4	5
Arthritis	1	2	3	4	5
Joint Pain	1	2	3	4	5
Low Back Pain	1	2	3	4	5
Neck Pain	1	2	3	4	5
Wrist/Hand Pain	1	2	3	4	5
Elbow Pain	1	2	3	4	5
Shoulder Pain	1	2	3	4	5
Hip Pain	1	2	3	4	5
Knee Pain	1	2	3	4	5
Ankle/Foot Pain	1	2	3	4	5
Pain b/t/shoulder blades	1	2	3	4	5

General

Fatigue	1	2	3	4	5
Malaise	1	2	3	4	5
Weakness, tiredness	1	2	3	4	5
Lightheadedness	1	2	3	4	5
Irritability	1	2	3	4	5
Constipation	1	2	3	4	5
Diarrhea	1	2	3	4	5
Feeling Foggy	1	2	3	4	5
Forgetfulness	1	2	3	4	5

Have you had an X-Ray or MRI is the past 6 months? YES OR NO

Have you ever had a steroid injection? YES OR NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Physicians' Review

_____ _____

Signature of Physician Date