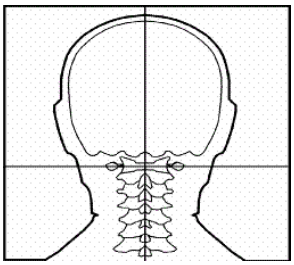

Welcome to our office! It is our purpose to serve you using gentle and precise chiropractic methods. Please complete this questionnaire thoroughly to help us evaluate your needs. Let us know if you have any questions or if you would like assistance.

Atlas Orthogonal Chiropractic

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What is the purpose of your visit today?

_____

_____

Have you received chiropractic care before?

☐ **Yes** ☐ **No** **LastVisit:**_____

Chiropractor and Practice Name:

_____

_____

Today's Date:_____

Your Name:_____

Date of Birth:_____ Age:_____ Sex:_____

SS#:_____

Marital Status:_____

#of Children:_____

Race/Ethnicity: _____

Home Street:_____

Suite/Apt:_____

City:_____ State:_____

Zip Code:_____

Home Phone:_____

Cell Phone:_____

Business Phone:_____

Email:_____

Preferred Method of Contact:

☐ Home Phone ☐ Cell Phone ☐ Work Phone

Employer:_____

Occupation:_____

Please check the type of care you desire to help us honor your needs:

☐ ***Relief Care*—symptomatic relief of pain or discomfort**

☐ ***Corrective Care*—correcting and relieving the cause of the problem and symptoms**

☐ ***Wellness Care*—correct areas of dysfunction and optimize my overall health**

☐ **I don't know and would like to talk more to the doctor about my needs**

Health History

Do you have a family medical physician? ☐ Yes☐ No Physician's Name(s):_____

Practice Name:_____ Date of Last Visit:_____ Purpose of Visit:_____

Have you had any surgeries or hospitalizations in the last five years? ☐ Yes ☐ No If yes, please describe:_____

Have you had a serious accident in the past five years? ☐ Yes ☐ No

Date of Accident:_____ ☐ Auto ☐ Work ☐ Home ☐ Other

Are you currently taking medications? ☐ Yes ☐ No

☐Anti-inflammatories ☐ Muscle Relaxers ☐ Pain Medication ☐ Antibiotics

☐Psychological ☐ Blood Pressure Pills ☐ Prescription Drugs

Please list ALL medications:_____

_____

_____

Smoking Status: ☐Current Every Day Smoker ☐Current Some Day Smoker ☐ Former Smoker

☐ Never Smoker ☐Smoker, Current Status Unknown ☐ Unknown if ever smoked

Women over 65: Have you had a mammogram ☐ Yes ☐ No

Men & Women over 65: Have you had a Pneumonia Vaccine? ☐ Yes ☐ No

Patient Initials_____

Review of Body Systems

Describe if you are (or in the last six months have been) suffering with conditions of the following:
Skin: □ Yes □ No _____
Neurological: □ Yes □ No _____
Eyes: □ Yes □ No _____
Ears/Nose/Throat: □ Yes □ No _____
Heart/Lungs: □ Yes □ No _____
Digestion: □ Yes □ No _____
Genitourinary: □ Yes □ No _____
Psychological: □ Yes □ No _____
Endocrine: □ Yes □ No _____

Please circle **if you now have or ever have had** any of the following illnesses:

Arthritis	Sinus Trouble	Ulcer	Polio	AIDS/HIV
Asthma	Hay Fever	Cancer	Rheumatic Fever	Dislocations
Allergies*	High Blood Pressure	Thyroid Trouble	TB	Scoliosis
Diabetes	Low Blood Pressure	Epilepsy	Multiple Sclerosis	Fracture
Heart Trouble	Pacemaker	Prostate Trouble	Kidney Trouble	□ **None Apply**

*Please list allergies: _____
_____

Please circle **if your father, mother or siblings** have had any of the following conditions:

Cancer	Headaches	Pinched Nerves	Arthritis	Stroke
Diabetes	Neck Problems	Osteoporosis	Bad Posture	Multiple Sclerosis
Heart Trouble	Back Problems	Scoliosis	High Blood Pressure	□ **None Apply**
Disc Problems	Joint Problems			

Neuromusculoskeletal Complaint(s): *(examples: headache, dull neck pain, hand numbness, etc.)*

Complaint #1_____ When did it start?_____
Is it □ Dull □ Sharp □ Shooting □ Stinging □ Burning □ Radiating
How often does it occur? □ Occasionally □ Intermittently □ Frequently □ Constantly
How would you rate pain with 0 being no pain and 10 being the worst pain?
□ 0 (no pain) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (worst)
What makes it better?_____
What makes it worse?_____
Has this condition existed in the past? □ No □ Yes If yes, when?_____
Are you getting □ Better □ Worse □ Same

Complaint #2_____ When did it start?_____
Is it □ Dull □ Sharp □ Shooting □ Stinging □ Burning □ Radiating
How often does it occur? □ Occasionally □ Intermittently □ Frequently □ Constantly
How would you rate pain with 0 being no pain and 10 being the worst pain?
□ 0 (no pain) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (worst)
What makes it better?_____
What makes it worse?_____
Has this condition existed in the past? □ No □ Yes If yes, when?_____
Are you getting □ Better □ Worse □ Same

Complaint #3_____ When did it start?_____
Is it □ Dull □ Sharp □ Shooting □ Stinging □ Burning □ Radiating
How often does it occur? □ Occasionally □ Intermittently □ Frequently □ Constantly
How would you rate pain with 0 being no pain and 10 being the worst pain?
□ 0 (no pain) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (worst)
What makes it better?_____
What makes it worse?_____
Has this condition existed in the past? □ No □ Yes If yes, when?_____
Are you getting □ Better □ Worse □ Same

Have you had recent treatment for these conditions? □ No □ Yes
If yes, list doctor/facility, treatment and date(s) of care:_____
_____
_____

Indicate if you have noticed changes in the following *since* your symptoms began:
□ Bowel Function □ Bladder Function □ Sexual Function □ None Apply

Do your present complaints affect the number of hours you work in a day? □ Yes □ No

Do your work activities aggravate your complaints? □ Yes □ No

How many hours do you work in a week?_____

Are you right or left handed? □ Left □ Right

Indicate your habits regarding the following:
Smoking (packs per **day**) _____
Alcohol (drinks per **day**) _____
Caffeine (drinks/cups per **day**) _____
Exercise (days per week) _____
Drug/Substance Abuse □ No □ Yes

Hobbies:
_____
_____
_____

Women Only:
Are you pregnant? □ Yes □ No Have your past pregnancies been normal? □ Yes □ No
_____Initials

Financial Information:

Is your condition due to: □ Auto Accident? □ Personal Injury? □ Work Injury? □ None
Do you have health insurance? □ Yes □ No

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in obtaining collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I understand and agree that all services rendered to me are charge directly to me and that I am personally responsible for payment at the time of service. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Your Initials_____

I will take care of my investment today by: □ Cash □ Check □ Credit Card

Is there anything else you would like us to know? □ Yes □ No

Your Signature:_____ Date:_____

Parent/Guardian Signature:_____* Date:_____

***I hereby authorize the Atlas Orthogonal Chiropractic staff to perform the necessary services my child may need.**

Doctor's Signature:_____ Date:_____