ATLAS CHIROPRACTIC

TODAY'S DATE ____________

PATIENT INFORMATION

Name ____ Preferred Name ______________________________

Date of Birth _______________________________ Age______

Insurance? ☐ **YES** ☐ **NO IF YES, WHAT INSURANCE DO YOU HAVE?** _____________________________________

Address___________________________________ City _____________________ State __________ Zip________

PLEASE CHECK THE APPROPRIATE BOXES

☐ MALE ☐ FEMALE ☐ NON BINARY ☐ PREFER NOT TO SAY

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPERATED ☐ DIVORCED

WHAT ARE YOUR PREFERRRED PRONOUNS?

☐ HE/HIM ☐ SHE/HER ☐ THEY/THEM

Phone # Cell __________________________ Home __________________________

Email Address ____

Employer ____ City/State __________________________

Emergency Contact ____ Phone ______________________________

How did you hear about us? ____

CHIEF COMPLAINT

Chief Complaint/What brings you in today? ____

How often does this bother you?____

When did this start? ____

Is Condition due to an accident? ☐ Yes ☐ No **(if yes please let front desk know)**

If yes, Accident date_________ Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other

What activity bothers it the most?____

When is your pain at its worst? Please check all that apply.

☐ Morning ☐ Daytime ☐ Evening ☐ Middle of the night ☐ Always the same

If 0 is no pain and 10 is the worst pain you can imagine, how would you rate your pain?

Right now _____ At its best _____ At its worst _____

Does your pain radiate/travel anywhere in your body? Yes No

If yes, where does it radiate? ____

How are your symptoms changing with time?

☐ Getting better ☐ Not Changing ☐ Worse

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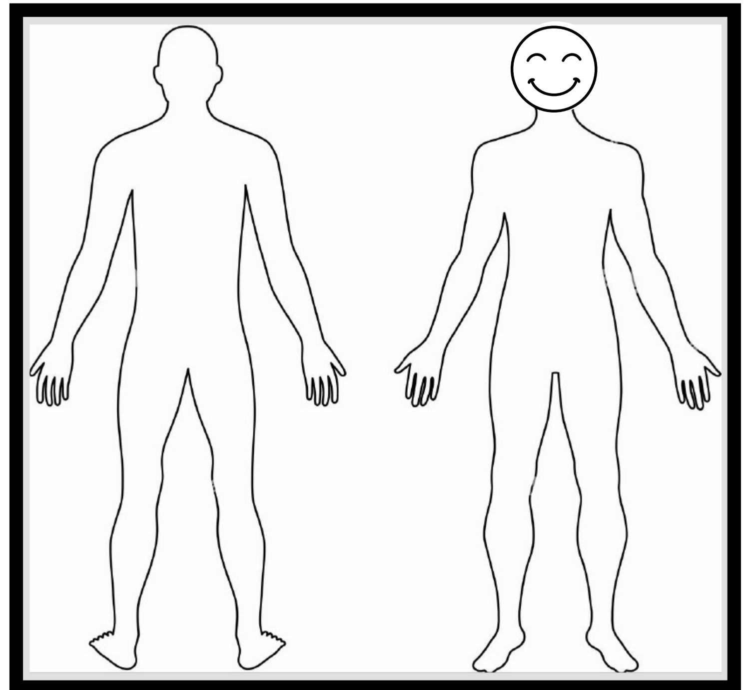
Please draw the appropriate symbol(s) in the area of pain
if unsure, please circle problem area(s)

ACHING	- - - -
NUMBNESS	o o o
BURNING	/ / / /
STABBING	(((((

PAIN CHART



Who else have you seen for this problem? Please check all that apply.

- ☐ Chiropractor
- ☐ Neurologist
- ☐ Primary Care Physician
- ☐ Massage Therapist
- ☐ Physical Therapist
- ☐ Other ________________

Please mark the effect each action listed below effects your pain level

	Increase	Decrease		Increase	Decrease
Sitting	☐	☐	Coughing/Sneezing	☐	☐
Rising from sitting	☐	☐	Household chores	☐	☐
Standing	☐	☐	Lifting objects	☐	☐
Walking	☐	☐	Reaching overhead	☐	☐
Lying down	☐	☐	Showering/Bathing	☐	☐
Bending forward	☐	☐	Looking side to side	☐	☐
Bending backward	☐	☐	Looking Up	☐	☐
Driving	☐	☐	Looking Downward	☐	☐
Twisting	☐	☐	Changing Positions	☐	☐

Please mark the treatments you have used.

	Helped	Worsened	Same		Helped	Worsened	Same
Medications	☐	☐	☐	Massage therapy	☐	☐	☐
Physical Therapy	☐	☐	☐	Acupuncture	☐	☐	☐
Chiropractic	☐	☐	☐	Brace Support	☐	☐	☐
Electric Stim/TENS	☐	☐	☐	Cognitive Therapy	☐	☐	☐
Hot Packs	☐	☐	☐	Cold Packs/Ice	☐	☐	☐

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MEDICAL HISTORY

Please mark the following conditions/diseases/symtpoms that you have been treated for.

GENERAL
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ APPENDICITIS
- ☐ ANOREXIA
- ☐ ANEMIA
- ☐ ALLERGIES
- ☐ AIDS/HIV
- ☐ ALCOHOLISM
- ☐ BRONCHITIS
- ☐ BULIMIA
- ☐ CANCER
- ☐ CATARACTS
- ☐ CHICKEN POX
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ EMPHYSEMA
- ☐ FRACTURES
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ HERNIA
- ☐ HERNIATED DISC
- ☐ HIGH CHOLESTEROL
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ METAL IMPLANT
- ☐ MIGRAINES
- ☐ M.S
- ☐ MUMPS
- ☐ OSTEOPEROSIS
- ☐ PNEUMONIA
- ☐ PROSTATE ISSUE
- ☐ PINCHED NERVE
- ☐ PACE MAKER
- ☐ RHEUMATOID ARTHRITIS
- ☐ STROKE
- ☐ THYROID ISSUE

CONSTITUTIONAL
- ☐ CHILLS
- ☐ INSOMNIA/SLEEPIG ISSUES
- ☐ EASY BRUISING
- ☐ FATIGUE
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

CARDIOVASCULAR
- ☐ BLOOD CLOTS
- ☐ BRONCHITIS
- ☐ BLEEDING DISORDER
- ☐ CHEST PAIN
- ☐ CATARACTS
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ PALPITATIONS

EAR/NOSE/THROAT
- ☐ DENTAL ISSUES
- ☐ EARACHES
- ☐ HEARING ISSUES
- ☐ NOSE BLEEDS
- ☐ SINUS ISSUES

GASTROINTESTIONAL
- ☐ ACID REFLUX
- ☐ CONSITPATION
- ☐ IBS
- ☐ NASUEA/VOMITING

MUSCULOSKELETAL
- ☐ ELBOW/WRIST PAIN
- ☐ FOOT/ANKLE PAIN
- ☐ HIP DISORDER
- ☐ KNEE INJURY
- ☐ MUSCLE SPASMS
- ☐ NECK PAIN
- ☐ POOR POSTURE
- ☐ SCOLLIOSIS
- ☐ STIFF JOINTS
- ☐ SWOLLEN JOINTS

NEUROLOGICAL
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ HEADACHES
- ☐ SEIZURES
- ☐ TREMORS
- ☐ PINS AND NEEDLES

RESPIRATORY
- ☐ COUGHING
- ☐ WHEEZING
- ☐ SHORTNESS OF BREATH

Other if not listed:____

How do you exercise? How often?

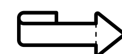
____

Women: How many children?_____ Pregnant? ☐ Nursing? ☐ Birth Control? ☐

Previous Surgeries and Dates____

List ALL medications you are currently taking:_______________________________________

____

NEXT PAGE 

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CANCELLATION POLICY

We require at least 24-hour notice of your cancellation. The"No-Show"fee is $25.00.
All fees will be due prior to seeing the doctor at future visits.
By signing below I understand this no show policy.
I also understand these fees have nothing to do with my co-pay or deductible and cannot be billed to my insurance company.

PRINT NAME: ____

SIGNATURE: ____

DATE: ____________________

HIPAA Compliance Patient Consent

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
- **The practice reserves the right to change the privacy policy as allowed by law.**
- **The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.**
- **The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.**
- **The practice may condition receipt of treatment upon execution of this consent.**

This consent was signed by: __________________________________
(PRINT NAME)

Signature: ________________________________ **DATE:** _____________