**Atlas Chiropractic Health Center**
1422 Harvard Ave.
Seattle, WA 98122
**Office:** 206-324-2225
**FAX:** 206-324-5244

## Confidential Patient Information

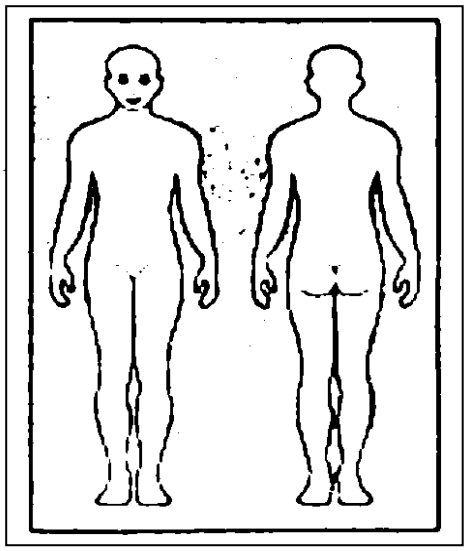
Date:_____

First Name: _____Last Name:_____Middle Initial: ____

## MAJOR COMPLAINT INFORMATION

What is your major complaint(s)?_____
_____
When did symptom(s) begin? _____
Have you experienced these symptoms before? □ yes no When?_____
Are these symptoms due to an auto accident or work injury? yes no
Have you reported accident to: insurance yes no employer yes no

Using the symbols in the Pain Index, mark the areas on the illustration below where you are experiencing pain, followed by a number from 0 – 10 indicating the extent of the pain. (0 being no pain, 10 being severe)



**PAIN INDEX**
**B** Burning
**S** Sharp/Stabbing

If this is an injury, describe what happened:
_____
_____
_____
_____

On a scale of 0-10, how do you feel now? (0 being no pain, 10 being worst)

0 1 2 3 4 5 6 7 8 9 10

**Check appropriate boxes:**
Symptoms: come & go came on gradually came on suddenly
Symptoms have persisted for: days weeks months years
Symptoms are worse in: AM midday PM night
Symptoms are better in: AM midday PM night
Type of pain: Dull Sharp Throbbing Burning Radiating
Do you have **Pins&Needles** in arms or legs? ___yes ___no specify:_____
What activities make symptoms worse?_____
What activities make symptoms better?_____
Do you ever have impairment of bowel or bladder function? ___yes ___no

## INDICATE, CHECK (√) ANY DIFFICULTY TO PERFORM THE FOLLOWING ACTIVITIES

| | | | | | |
|---|---|---|---|---|---|
| coughing or sneezing | sitting | sleeping | kneeling | stooping | lying on back |
| bending over forward | getting out of car | climbing | pushing | gripping | dressing self |
| lying flat on stomach | turning over in bed | balancing | pulling | reaching | sex activity |
| walking short distances | standing > 1 hr | lying flat on side with knees bent | | | |
| bending forward to brush teeth | | | | | |

Have you consulted a doctor for this condition? ___yes ___no Doctor's name:_____
Date consulted:_____ Diagnosis:_____
Does this condition interfere with your sleep ____ yes ____no
Do you sleep on your: ____ stomach _____back ____side
Do you sleep with a pillow? ___yes ___no if yes how many?_____
Do you wear a heel lift or orthotic (circle one)? ___yes: ___right ___left ___no

## HEADACHES

Do you get headaches? ___yes ___no How often:_____
Nausea, vomiting or visual disturbances? ___yes ___no
When was your last eye exam? ___1-6 mo. ___7-12mo. ____yrs. ___ never
Abnormal blood pressure? ___yes ___no ___high ___low
Do you have jaw problems? ___yes ___no

## OTHER HEALTH HISTORY

Date of last physical exam? _____ reason_____ Date of most recent x-rays_____
**If female,** are you pregnant? ___yes ___no ___ not sure
List all medications you are taking now, including over the counter, and reason for taking them:_____
_____
_____
Are you allergic to any medication? ___yes ___no if yes, what?_____
Have you ever been hospitalized or had surgery? ___yes ___no if yes, please list below:
_____ Date:_____ _____ Date:_____
_____ Date:_____ _____ Date:_____
Do you have a family physician? ___yes ___no Name of physician:_____
Phone #:_____ Address:_____
Have you ever been to a chiropractor? ___yes ___no date last seen?_____
Have you had any accidents, falls or broken bones? (anything from auto to sprained ankle)_____
_____
_____

## ADDITIONAL COMPLAINTS

**CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:**

| | | | |
|---|---|---|---|
| ___ Appendicitis | ___ Tuberculosis | ___ Diabetes | ___ Alcoholism |
| ___ Scarlet Fever | ___ Whooping Cough | ___ Cancer | ___ Venereal Disease |
| ___ Diphtheria | ___ Anemia | ___ Heart Disease | ___ Arthritis |
| ___ Typhoid Fever | ___ Measles | ___ Goiter | ___ Epilepsy |
| ___ Pneumonia | ___ Mumps | ___ Influenza | ___ Mental Disorder |
| ___ Rheumatic Fever | ___ Small Pox | ___ Pleurisy | ___ Lumbago |
| ___ Polio | ___ Autoimmune Disease | ___ Stroke | ___ Eczema |
| ___ Malaria | ___ Chicken Pox | ___ Thyroid Disease | ___ Osteoporosis |

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**CHECK ANY OF THE FOLLOWING YOU NOW HAVE OR HAVE HAD IN THE PAST:**
**F = frequently O = occasionally N = never**

| | F O N | |
|---|---|---|
| **MS** | __ __ __ | Headache |
| | __ __ __ | Neck Pain |
| | __ __ __ | Pain between shoulders |
| | __ __ __ | shoulder pain |
| | __ __ __ | arm pain/tingling/numb |
| | __ __ __ | Mid back pain |
| | __ __ __ | Low Back Pain |
| | __ __ __ | Hip Pain |
| | __ __ __ | Leg Pain/Tingling/Numb |
| | __ __ __ | Walking Problems |
| | __ __ __ | Difficult Chewing |
| **NS** | __ __ __ | Dizziness |
| | __ __ __ | Balance |
| | __ __ __ | Blurred Vision |
| | __ __ __ | Loss of Concentration |
| | __ __ __ | Forgetfulness |
| | __ __ __ | Stress |
| | __ __ __ | Depression/Confusion |
| | __ __ __ | Anxiety/Nervousness |
| | __ __ __ | Sleep Disturbance |
| | __ __ __ | Energy Loss/Fatigue |
| | __ __ __ | Buzzing/Ringing in Ears |
| | __ __ __ | Fainting |
| | __ __ __ | Palpitations |
| **GI** | __ __ __ | Indigestion |
| | __ __ __ | Poor/Excessive Appetite |
| | __ __ __ | Excessive Thirst |
| | __ __ __ | Frequent Urination |
| | __ __ __ | Vomiting |
| | __ __ __ | Constipation |
| | __ __ __ | Sudden changes in weight in past 6 months |

| | F O N | |
|---|---|---|
| | __ __ __ | Hemorrhoids |
| | __ __ __ | Liver Trouble |
| | __ __ __ | Gall Bladder Problems |
| | __ __ __ | Weight Trouble |
| | __ __ __ | Abdominal Cramps |
| | __ __ __ | Gas/Bloating after meals |
| | __ __ __ | Heartburn |
| | __ __ __ | Black Bloody Stool |
| | __ __ __ | Colitis |
| **GU** | __ __ __ | Kidney/Bladder Trouble |
| | __ __ __ | Painful Excessive Urination |
| | __ __ __ | Discolored Urine |
| **CVR** | __ __ __ | Poor Circulation |
| | __ __ __ | Chest Pain |
| | __ __ __ | Short Breath |
| | __ __ __ | Blood Pressure Problems |
| | __ __ __ | Irregular Heart Beat |
| | __ __ __ | Heart Problems |
| | __ __ __ | Lung Problems/Congestion |
| | __ __ __ | Varicose Veins |
| | __ __ __ | Ankle Swelling |
| **ENT** | __ __ __ | Vision Problems |
| | __ __ __ | Dental Problems |
| | __ __ __ | Sore Throat |
| | __ __ __ | Fever |
| | __ __ __ | Ear Aches |
| | __ __ __ | Hearing Difficulty |
| | __ __ __ | Allergy |
| | __ __ __ | Bloody Nose |

**Family History**:

| | Y | N |
|---|---|---|
| Cancer | __ | __ |
| Heart Disease | __ | __ |
| Stroke | __ | __ |
| Diabetes | __ | __ |
| Arthritis | __ | __ |
| Osteoporosis | __ | __ |
| High Cholesterol | __ | __ |

**Habits:**

Do you smoke __ __
How much _____/day
Alcohol_____
Vitamins_____
_____
How old is the bed you sleep in?_____

**Female**

| | |
|---|---|
| Menstrual Irreg. | __ __ |
| Menstrual Cramp | __ __ |
| Vaginal Pain | __ __ |
| Breast Pain/lump | __ __ |
| Sex. Trans. Dis. | __ __ |
| Are you pregnant | __ __ |

**Male**

| | |
|---|---|
| Prostate dysfunct. | __ __ |
| Sexual Dysfunct. | __ __ |
| Sex. Trans. Dis. | __ __ |
| Trouble Urinating | __ __ |

## EMERGENCY CONTACT

Name:_____ Relation:_____
Home Phone: _____ Work Phone: _____
Address: _____
City/State/Zip: _____

## INSURANCE INFORMATION

Insurance Company: _____ Phone#:_____
Address: _____
City/State/Zip: _____
Insured's Name: _____ Insured's SS# _____
Group #: _____ Insured's Birth Date:_____
Insured's Employer: _____ ID# _____

## PERSONAL INFORMATION

Address: _____
City/State/Zip: _____
Home Phone: _____ Work Place: _____
Cell Phone: _____ email: _____
SS#: _____ Date of Birth: _____ Age: _____ M___ F___
Drivers License #: _____
Marital Status: ___S ___M ___D ___W Spouse's name: _____
Your Occupation :_____Employer's Name: _____
Work Address: _____
City/State/Zip: _____
**How were you referred to our office?** _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Atlas Chiropractic Health Center** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **Atlas Chiropractic Health Center** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Any accounts that are referred for collection will have a service fee charged at the time of referral to cover additional handling costs. Should legal action be necessary for the recovery of any monies due under this agreement, the prevailing party shall be entitled to recover attorney fees and court costs from the other party. Any dispute between parties shall be resolved by binding arbitration. It is not our intention to cause you undue hardship, however we must collect our receivables as efficiently as possible in order to continue our service to the community. Interest of 1% per month will be charged on delinquent accounts. If you discontinue your care, all charges are due and payable immediately.

Patient's Signature:_____ Date:_____
Soc Sec. #:_____ Driver's License#:_____
Guardian or Spouse Signature Authorizing Care:_____