



Date: _____

First Name: _____

Last Name: _____

Middle Initial: _____

MAJOR COMPLAINT INFORMATION

What is your major complaint(s)? _____

When did symptom(s) begin? _____

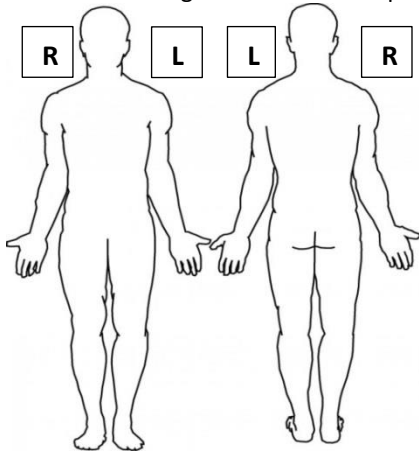
Have you experienced these symptoms before? Circle YES or NO When? _____

Are symptoms due to an auto accident or work injury? Circle YES or NO

Please circle if you have reported accident to: Auto Insurance or Employer

PAIN DIAGRAM

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



PAIN INDEX

- ~ Spasm
Δ Aching/Dull
* Numbness/Tingling
Burning
\ Sharp/Stabbing
T Throbbing
R Radiating

If this is an injury, describe what happened:

Blank lines for describing an injury.

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

Scale from 0 to 10 with a line for marking the current pain level.

Check all that apply:

Symptoms:

- come & go
are constant
came on gradually
came on suddenly

Symptoms have persisted for:

- days
weeks
months
years

Symptoms are worse in:

- AM
midday
PM

Symptoms are better in:

- AM
midday
PM

Do you have "pins & needles" in arms or legs? If yes, please specify: _____

What activities make symptoms worse? _____

What activities make symptoms better? _____

HEADACHES

Do you get headaches? If yes, how often? _____

Nausea, vomiting, or visual disturbances? ___ yes ___ no

When was your last eye exam? ___ 1-6 mo. ___ 7-12 mo. ___ years ___ never

Abnormal blood pressure? ___ yes ___ no ___ high ___ low

Do you have jaw problems? ___ yes ___ no



Atlas Chiropractic Health Center

DAILY ACTIVITIES AFFECTED BY CONDITION

Please circle all that apply:

- | | | | | | |
|--------------------------------|-------------------------|-----------|--------------|-------------------------------|---------------|
| coughing or sneezing | walking short distances | 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 |
| lying on side w/ knees bent | standing > 1 hr. | sitting | holding baby | lifting | bathing |
| bending forward to brush teeth | carrying bag/backpack | driving | exercise | other (please specify): _____ | |

Have you consulted a doctor for this condition? If yes, please provide doctor's name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? ___ yes ___ no If yes, how so? _____

How do you sleep? ___ On stomach ___ on back ___ on side ___ other (please explain: _____)

Do you sleep with a pillow? ___ yes ___ no If yes, how many? ___

Do you wear a *heel lift* or *orthotic* (circle one)? ___ yes ___ no If yes: ___ right ___ left

OTHER HEALTH HISTORY

Date of last physical exam? _____ Reason for exam? _____ Date of most recent x-rays? _____

List all medications you are taking now, including over-the-counter, and reason(s) for taking them:

Medicine	Dosage/Frequency	Reason for taking medicine

Please list all known allergies: _____

Have you ever been hospitalized or had surgery? ___ yes ___ no If yes, please list below:

Date: _____ Reason: _____ Date: _____ Reason: _____

Date: _____ Reason: _____ Date: _____ Reason: _____

Do you have a family physician? ___ yes ___ no If yes, physician's name: _____

Physician's phone #: _____ City and state of physician's practice: _____

Have you ever received chiropractic care? ___ yes ___ no If yes, date last seen: _____

Have you ever had a concussion? ___ yes ___ no If yes, please explain: _____

Have you ever had any broken bones? ___ yes ___ no If yes, please explain: _____

Have you ever had any accidents resulting in serious injury? If yes, please explain: _____

Have you ever had professional clinical massage? ___ yes ___ no

Do you have a massage therapist you see regularly? ___ yes ___ no

Do you see or have you ever seen a medical specialist? ___ yes ___ no If yes, what specialty? _____

Medical specialist's name: _____ City and state of specialist's practice: _____

How often do you exercise? _____

What type(s) of physical exercise do you enjoy or prefer? _____

Confidential Health History



Atlas Chiropractic Health Center

ADDITIONAL COMPLAINTS

Check any of the following disease(s) you have or have ever had:

- | | | | | |
|--|---------------------------------------|--|--------------------------------------|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Addiction | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Eczema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> AIDS | <input type="checkbox"/> Gout |

REVIEW OF SYSTEMS

Check any of the following you now have or have had in the past:

F = frequently **O = occasionally** **N = never**

<p>Head/Ears/Eyes/Nose/Throat</p> <input type="checkbox"/> blurred vision <input type="checkbox"/> floaters in vision <input type="checkbox"/> hearing loss <input type="checkbox"/> ringing in ears <input type="checkbox"/> loss of taste <input type="checkbox"/> loss of smell <input type="checkbox"/> glaucoma <input type="checkbox"/> ear infection <input type="checkbox"/> sinusitis <input type="checkbox"/> postnasal drip <input type="checkbox"/> nasal polyps <input type="checkbox"/> strep throat <input type="checkbox"/> Mononucleosis <input type="checkbox"/> dental issues	<p>Neurological</p> <input type="checkbox"/> dizziness <input type="checkbox"/> balance difficulty <input type="checkbox"/> blurred vision <input type="checkbox"/> loss of concentration <input type="checkbox"/> depression/confusion <input type="checkbox"/> anxiety/nervousness <input type="checkbox"/> sleep disturbance <input type="checkbox"/> fatigue/energy loss <input type="checkbox"/> fainting <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic pain <input type="checkbox"/> Mood disorders <input type="checkbox"/> Other: _____	<p>Gastro-Intestinal</p> <input type="checkbox"/> ulcer <input type="checkbox"/> anorexia/bulimia <input type="checkbox"/> food sensitivities <input type="checkbox"/> indigestion <input type="checkbox"/> unusual appetite <input type="checkbox"/> excessive thirst <input type="checkbox"/> frequent urination <input type="checkbox"/> vomiting <input type="checkbox"/> constipation <input type="checkbox"/> sudden weight change <input type="checkbox"/> hemorrhoids <input type="checkbox"/> liver issues <input type="checkbox"/> abdominal cramps <input type="checkbox"/> gas/bloating <input type="checkbox"/> heartburn <input type="checkbox"/> black bloody stool <input type="checkbox"/> diverticulitis/-osis <input type="checkbox"/> gall bladder disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Celiac <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Irritable Bowel Syndrome	<p>Musculoskeletal</p> <input type="checkbox"/> headache <input type="checkbox"/> neck pain <input type="checkbox"/> pain between shoulders <input type="checkbox"/> arm pain/tingling/numb <input type="checkbox"/> mid back pain <input type="checkbox"/> low back pain <input type="checkbox"/> hip pain <input type="checkbox"/> leg pain/tingling/numb <input type="checkbox"/> walking problems <input type="checkbox"/> chewing difficulty
<p>Cardiovascular</p> <input type="checkbox"/> poor circulation <input type="checkbox"/> chest pain <input type="checkbox"/> shortness of breath <input type="checkbox"/> irregular blood pressure <input type="checkbox"/> irregular heart beat <input type="checkbox"/> heart problems <input type="checkbox"/> lung issues/congestion <input type="checkbox"/> varicose veins <input type="checkbox"/> ankle swelling	<p>Genitourinary</p> <input type="checkbox"/> kidney stones <input type="checkbox"/> prostate issues <input type="checkbox"/> erectile dysfunction <input type="checkbox"/> bedwetting <input type="checkbox"/> PMS symptoms <input type="checkbox"/> infertility <input type="checkbox"/> urinary tract infection <input type="checkbox"/> yeast infection <input type="checkbox"/> abnormal PAP <input type="checkbox"/> sexually transmitted disease <input type="checkbox"/> decreased libido <input type="checkbox"/> menstrual cramping <input type="checkbox"/> menstrual irregularity <input type="checkbox"/> vaginal pain	<p>Family History Has your: <i>Grandmother, Grandfather, Father, Mother, Sister, Brother, Daughter, or Son ever had:</i></p> <input type="checkbox"/> cancer <input type="checkbox"/> heart disease <input type="checkbox"/> stroke <input type="checkbox"/> arthritis <input type="checkbox"/> osteoporosis <input type="checkbox"/> high cholesterol Other (please explain): _____	<p>Habits:</p> Do you smoke? _____ _y _n How many per day? _____ Do you drink alcohol? _____ _y _n How much per day? _____ Do you consume caffeine? _____ _y _n How much per day: _____ List vitamins/supplements: _____ Water intake: _____ ounces per day How old is your bed? _____ Sleep quality? _____ Rate your stress level: <input type="radio"/> Stress free <input type="radio"/> Low stress <input type="radio"/> Moderate stress <input type="radio"/> High stress <input type="radio"/> The worst possible stress Stress factors: <i>Check all that apply.</i> <input type="radio"/> Relationship <input type="radio"/> Family <input type="radio"/> Work <input type="radio"/> School <input type="radio"/> Other: _____ _____
<p>Integumentary</p> <input type="checkbox"/> dry skin <input type="checkbox"/> psoriasis <input type="checkbox"/> eczema <input type="checkbox"/> acne	<p>Constitutional</p> <input type="checkbox"/> poor appetite <input type="checkbox"/> weakness <input type="checkbox"/> sudden weight change <input type="checkbox"/> fever <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> fainting <input type="checkbox"/> difficulty losing weight	<p>Endocrine</p> <input type="checkbox"/> thyroid issues <input type="checkbox"/> hypoglycemia <input type="checkbox"/> low energy <input type="checkbox"/> swollen glands <input type="checkbox"/> polycystic ovarian syndrome	

Confidential Health History

Name _____



Atlas Chiropractic Health Center

EMERGENCY CONTACT

Name: _____ Relation: _____
Phone: _____ Is this a cell phone? yes no Work Phone: _____
Address: _____ City/State/Zip: _____

INSURANCE INFORMATION

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

PERSONAL INFORMATION

Address: _____ City/State/Zip: _____
Phone: _____ Is this a cell phone? yes no Work Phone: _____
Email: _____
Date of Birth (mm/dd/yyyy): ___/___/___ Legal Gender (for insurance use): female male
SS#: _____ Driver License #: _____ US State of Issue: _____
Occupation: _____ Circle one: *full-time* *part-time* School or Employer's Name: _____
Work or School City/State: _____
How were you referred to our office? Single Married Partnered Divorced Widowed

Optional questions:

Gender Identity: female male transgender non-binary other: _____
My preferred pronouns are: she/her he/him them/they other: _____

PLEASE READ, SIGN, AND DATE BELOW

I hereby acknowledge that the information provided above is true and accurate. 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 my financial responsibility. Any dispute between legal 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 immediately.

Patient Signature: _____ Date: _____

Guardian/Spouse Signature Authorizing Care: _____ Date: _____

Printed Guardian/Spouse Full Name: _____

Confidential Health History