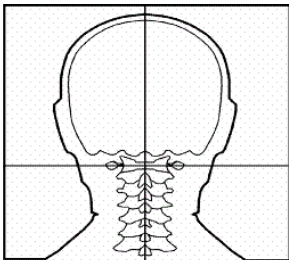

Welcome to our office! It is our purpose to serve you using gentle and precise chiropractic methods. Please complete this questionnaire thoroughly to help us evaluate your needs. Let us know if you have any questions or if you would like assistance.

Atlas Orthogonal Chiropractic
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Today's Date:______________
Your Name:__________________________________
Date of Birth:______________ Age:_____ Sex:_____
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:__________________________________

What is the purpose of your visit today?
____
____
____

Have you received chiropractic care before?
☐ Yes ☐ No LastVisit:___________
Chiropractor and Practice Name:
____

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:___________________________________ Phone Number:_____________
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:____
____

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 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

Patient Initials______

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

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

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:**_____________

Doctor's Signature:____ **Date:**_____________