ATLAS FAMILY CHIROPRACTIC CENTER

Name:_____ Today's Date: _____

Name preferred:_____ Phone: (h) _____

Address:_____ (c) _____

_____ E-mail: _____

Sex: M / F Marital Status: Single / Married / Div / Widow

Occupation:_____ Spouse (name/age) _____

Age: ____ Date of Birth: _____ Children (names/ages) _____

_____ _____ _____

Emergency Contact Name & Number: _____ #: _____

Have you ever been to a chiropractor before? ____ Yes ____ No

HISTORY

A. CURRENT COMPLAINTS:

Specific complaints (please describe): _____

How would you describe the pain: Dull Aching Sharp Burning Throbbing Numbing

How often are your symptoms present? () Up to 25% () 26-50% () 51-75% () 76-100%

Does the pain radiate: __ Yes __ No If yes, to where: Shoulder Arm Hand/Wrist Hip Leg Foot

When are your symptoms the worst? ____ Morning ____ Afternoon ____ Evening ____ Always the same

What makes them better? __ Sitting __ Standing __ Rest __ Meds __ Ice __ Heat

Other, please explain: _____

What makes them worse? __ Sitting __ Standing __ Walking __ Lifting Other: _____

Have you noticed a change in: __ Bowel Function __ Bladder Function __ Sexual Function __ None to All

B. Check any of the following activities that are more difficult because of your symptoms:

____ Lifting ____ Bending ____Walking ____ Sleeping

____ Sitting ____ Standing ____ Exercising ____ Other: _____

C. HISTORY OF CONDITIONS: Please check all symptoms you have experienced in the past:

___headaches	___pins and needles in legs	___shoulder pain	___loss of smell / taste
___neck pain	___pins and needles in arms	___elbow pain	___dizziness / loss of balance
___mid back pain	___TMJ / jaw pain	___hand/wrist pain	___high BP / heart disease
___low back pain	___numbness in fingers	___hip pain	___depression / anxiety
___sleeping problems	___numbness in toes	___knee pain	___history of cancer
___arthritis	___buzzing in ears	___foot / ankle pain	___osteoporosis
___scoliosis	___ asthma / allergies	___visual problems	___diabetes
___carpal tunnel	___difficulty urinating	___hearing loss	___digestive problems

Others, please list: _____

D. MEDICAL HISTORY:

Have you ever been hospitalized? ___ Yes ___ No Briefly explain: _____

Any surgeries? (Type, year) _____

Any auto accidents? (List by year) _____

List medications you are currently taking and for what: _____

Are you allergic to any medications? ___ Yes ___ No If yes, please list: _____

Do you smoke: No Yes (amount) _____ Females: Are you pregnant? Yes No Unsure

Do you have health insurance? Yes No

If Yes, circle one: BC/BS Cigna PPO U.H.C. PPO Aetna PPO Medicare Kaiser P. Coventry
NCAS Tricare Cigna HMO U.H.C. HMO Aetna HMO Medicaid Other: _____

E. FAMILY HISTORY: Put ***M** for Mother, ***F** for Father, ***S** for Spouse and ***C** for Children.

____ Neck Pain	____ Headaches	____ Heart Disease	____ Disc Problems
____ Low Back Pain	____ Scoliosis	____ Cancer	____ Severe Auto Accidents
____ Joint Pain	____ Arthritis	____ Sports Injuries	____ Work related injuries

PAIN DIAGRAM

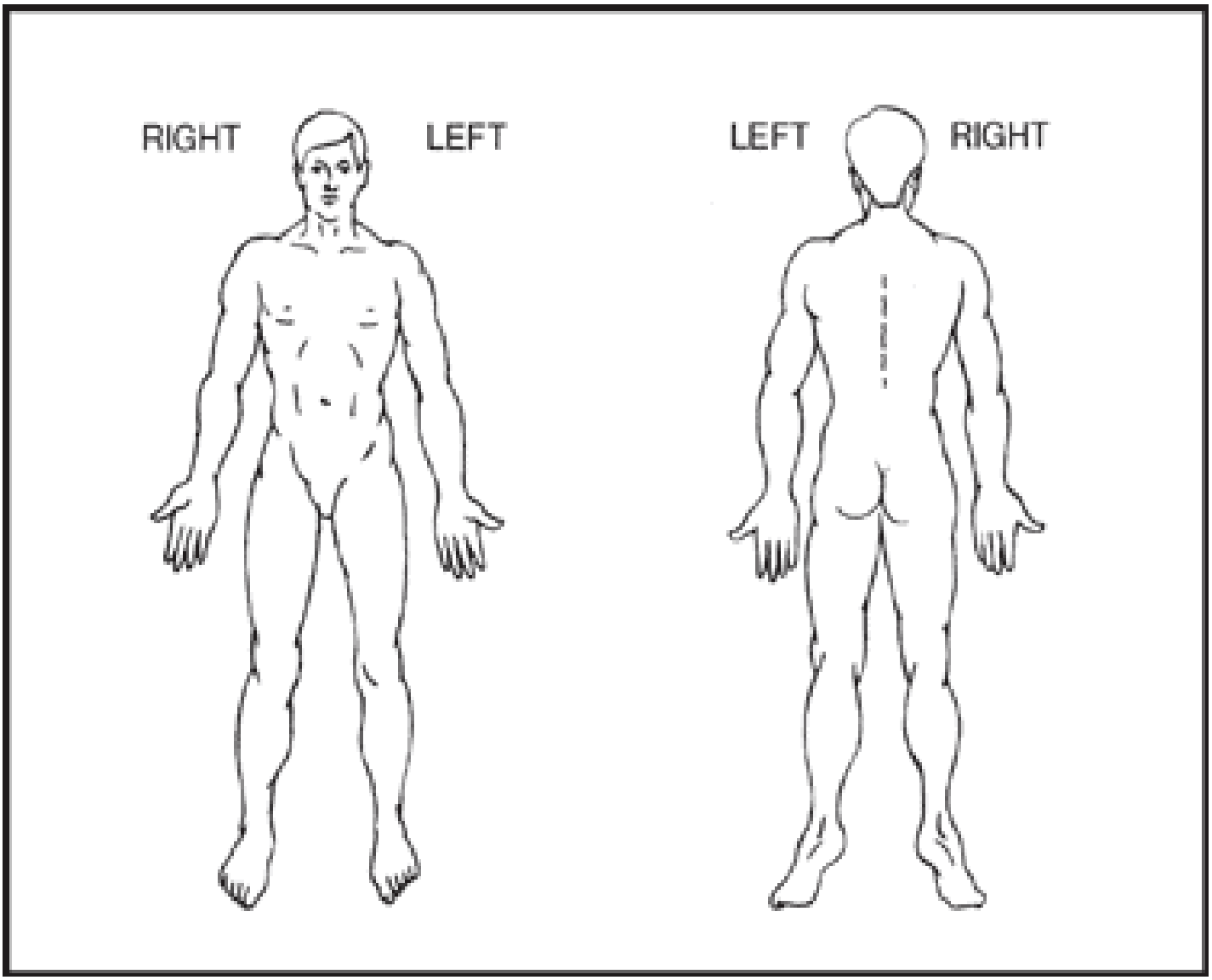
Complete the following diagram by using the letters to indicate areas of pain.

X: Pain / Achiness / Stiffness

T: Tingling **Name:_____** **Date:____/____/____**

N: Numbness

B: Burning



X-Ray Consent Form

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor has my permission to perform, if necessary, an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menses: _____

_____ _____

(Patient's signature) **(Date)**

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your personal health information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE: This Notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGMENT

By subscribing my name below, I acknowledge my understanding and agreement to its terms.

_____ _____

(Patient's signature) **(Date)**