

# Atlas Chiropractic Registration & History

## Patient Information

Date: \_\_\_/\_\_\_/\_\_\_

Patient: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex:  M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Patient SS #: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Occupation: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Insurance

**\*Be sure to provide the receptionist with all health insurance cards and photo ID**

### ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Atlas Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the signature on all insurance submissions.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Responsible Party Signature Relationship Date

## Accident Information

Is this condition due to an accident?  Yes  No Type of accident:  Auto  Work  Home  Other Injury Date: \_\_\_\_\_

To whom have you made a report of your accident?  Auto Insurance  Employer  Worker Comp  Other: \_\_\_\_\_

**\*Are you pregnant**  Yes  No Due Date: \_\_\_\_\_ Comments: \_\_\_\_\_

## Patient Condition

Primary reason for visit: \_\_\_\_\_

How did this occur?: \_\_\_\_\_

How long have you had this pain? \_\_\_\_\_ Years / Months / Weeks / Days

Symptoms appeared:  Gradually  Suddenly

Mark an X on the picture to the right where you are having pain or discomfort --->

Type of pain:  Aching  Burning  Diffused  Dull  Numbness  Sharp  
 Shooting  Throbbing  Tightness  Tingling

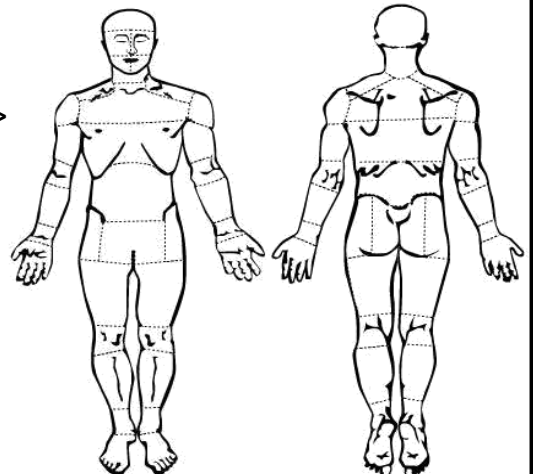
How frequently do you have this pain? (Check one below):  
 Constant  Frequent  Intermittent  Occasional

Symptoms are aggravated by: \_\_\_\_\_

Symptoms are reduced by: \_\_\_\_\_

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? \_\_\_\_\_



\*\*Turn Over\*\*

## Patient Condition (cont.)

**Second** reason for visit: \_\_\_\_\_

How did this occur?: \_\_\_\_\_

How long have you had this pain? \_\_\_\_\_ Years / Months / Weeks / Days

Symptoms appeared:  Gradually  Suddenly

Mark an X on the picture to the right where you are having pain or discomfort ---->

Type of pain:  Aching  Burning  Diffused  Dull  Numbness  Sharp

Shooting  Throbbing  Tightness  Tingling

How frequently do you have this pain? (Check one below):

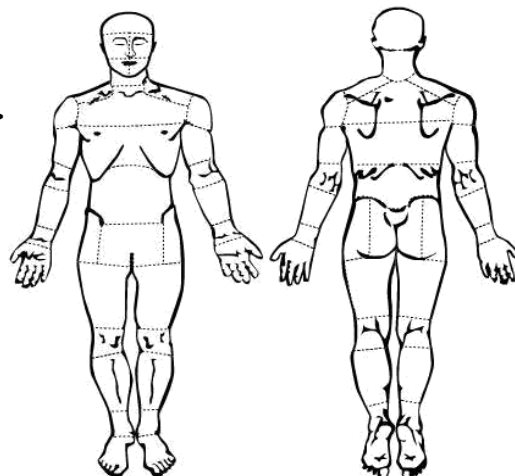
Constant  Frequent  Intermittent  Occasional

Symptoms are aggravated by: \_\_\_\_\_

Symptoms are reduced by: \_\_\_\_\_

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? \_\_\_\_\_



**Third** area of discomfort: \_\_\_\_\_

How did this occur?: \_\_\_\_\_

How long have you had this pain? \_\_\_\_\_ Years / Months / Weeks / Days

Symptoms appeared:  Gradually  Suddenly

Mark an X on the picture to the right where you are having pain or discomfort ---->

Type of pain:  Aching  Burning  Diffused  Dull  Numbness  Sharp

Shooting  Throbbing  Tightness  Tingling

How frequently do you have this pain? (Check one below):

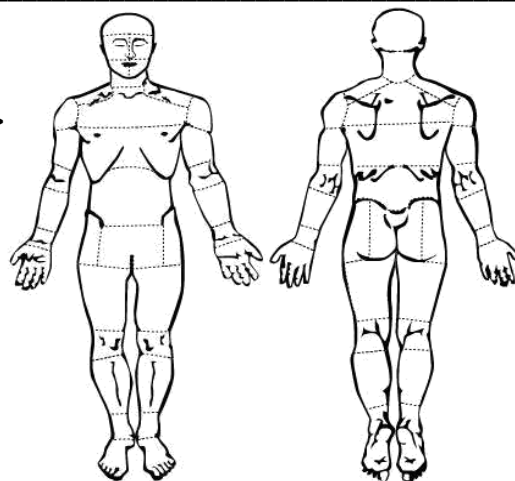
Constant  Frequent  Intermittent  Occasional

Symptoms are aggravated by: \_\_\_\_\_

Symptoms are reduced by: \_\_\_\_\_

Rate the severity of your pain (Circle one): 1 2 3 4 5 6 7 8 9 10

What time of day is the pain most noticeable? \_\_\_\_\_



## Health History

\*Please check **all** conditions below that you currently have or have had in the past\*

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heartburn/Acid reflux	<input type="checkbox"/> Menstral irregularities	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Dependency	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Constipation	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Ringing in the ears
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Mumps	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Herpes	<input type="checkbox"/> Nervousness/Anxiety	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Asthma/Short of breath	<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Emphysema	<input type="checkbox"/> IBS	<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/> Tumors/Growths
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pinched nerve	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Upset stomach
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Headaches	<input type="checkbox"/> Measles	<input type="checkbox"/> Polio	<input type="checkbox"/> Vaginal infections

Any other conditions not listed above: \_\_\_\_\_

## Health History (cont.)

What treatment have you already received for your condition?     Surgery Date(s): \_\_\_\_\_  
 Physical Therapy Date(s): \_\_\_\_\_     Chiropractic Services Date(s): \_\_\_\_\_     None  
 Name and address of other doctor(s) who have treated you for your condition: \_\_\_\_\_

**Date of last:**

Spinal Exam: \_\_\_\_\_    Chest X-Ray: \_\_\_\_\_    Urine Test: \_\_\_\_\_  
 Dental X-Ray: \_\_\_\_\_    MRI, CT-Scan, Bone Scan: \_\_\_\_\_

<b>Injuries/Surgeries you have had:</b>	<u>Description</u>	<u>Date(s)</u>
Broken Bones/Fractures:	_____	_____
Dislocations:	_____	_____
Head Injuries:	_____	_____
Surgeries:	_____	_____

### Medications


### Allergies


## Daily Habits

**\*What daily activities/duties are difficult for you due to the pain you're having? (ex. work, exercise, household chores, etc.)**

<u>Exercise</u>	<u>Work Activity</u>	<u>Habits</u>	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day: _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week: _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day: _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason: _____

## Family/Past History

Are there any conditions that are common in your family? (ex. cancer, diabetes, rheumatoid arthritis, etc.) \_\_\_\_\_

Have you ever suffered from anything similar before this episode?     Yes     No    If yes, how long did it last? \_\_\_\_\_

Did you receive care from any doctor(s)?     Yes     No    If yes, what type of doctor(s)? \_\_\_\_\_

What did you do to make it better? \_\_\_\_\_

Is there anything else that needs to be addressed about this condition? \_\_\_\_\_

\*By signing below, I certify that all information provided on these forms is true to the best of my knowledge.

Print: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **TERMS OF ACCEPTANCE**

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one goal:

**TO LOCATE, ANALYZE, AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM**

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

**WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS**

**WE DO NOT OFFER TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THEN VERTEBRAL SUBLUXATIONS.**

**WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S)**

**THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!!!**

I, \_\_\_\_\_, having read the above statement, and understanding it fully,  
(Please Print Name)

**do undertake chiropractic health care on the basis.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

---

## **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

By signing below, I indicate that a copy of Atlas Chiropractic Notice of Privacy Practices has been made available to me and understand that my signature indicates my consent to the use and disclosure of protected health information by Atlas Chiropractic as described in that notice.

\_\_\_\_\_  
Signature

(Legal Guardian's Signature if Minor)

\_\_\_\_\_  
Date