Atlas Patient Registration & History

Date: ____/____/_____

Patient: _____ Birthdate: ____/____/_____ Age:_____ Sex: ☐M ☐F

Address: _____City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

Email: _____ SSN: _____

Occupation: _____ Employer: _____

Employer's Address: _____City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Status: ☐Single ☐Married ☐Divorced ☐Widowed Children : _____ Ages: _____

Spouse's Name: _____ Birthdate: ____ /____ /_____ Occupation: _____

Whom may we thank for referring you?_____

EMERGENCY CONTACT: Name: _____ Best Contact #: _____ Relationship: _____

1. Preferred Language: _____
2. Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer
3. Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer
4. Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

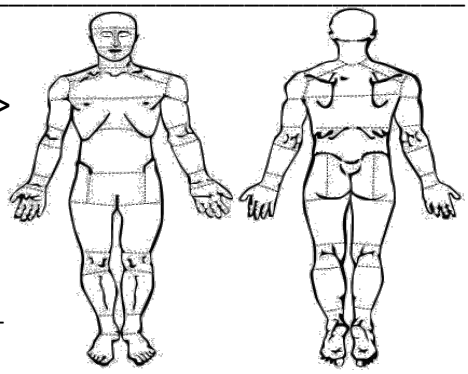
Primary reason for visit: _____

How did this occur? _____

Symptoms appeared: ☐ Gradually ☐ Suddenly

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

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? _____

Please list any other pain, health problems, symptoms, and/or complaints, in order of severity.

1.	For how long?
2.	For how long?
3.	For how long?

√ Please check all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Chest Pain/ Short of Breath
☐ Dizziness	☐ Asthma ☐ Freq. Upper Respiratory Infections
☐ Ear Infections	☐ Heart Palpatations/ Murmur
☐ Ringing/Buzzing in Ears	☐ Stomach/Digestive Issues ☐ Ulcers/Acid Relux/Hearburn
☐ Sinus Problems/ Allergies - to : _____	☐ Low Back Pain
☐ Pain Behind Eyes ☐ Blurred Vision	☐ Sciatica R L
☐ Freq. Sore Throats/ Throat Infection	☐ Hip Pain R L
☐ High Blood Pressure	☐ Diarrhea/Constipation/Excess Gas
☐ Upper Back Pain	☐ Freq. Urination/Urinary Tract Infections
☐ Shoulder Pain R L	☐ Knee Pain R L
☐ Wrist Pain R L	☐ Pain/Numb/Ting/Wk/Cramping in Legs/Feet/Toes
☐ Pain/Numb/Ting/Wk/Cramping Arm/Hand/Fingers	☐ Cold/Burn/Itchy/Swelling in Feet
☐ Cold/Burning/Itchy Hands	☐ Excessive Cramping/Irregular Periods
☐ Thyroid Condition	☐ Trouble Getting Pregnant/Miscarriages
☐ Fatigue/Low Energy Levels	☐ Impotence
☐ Insomnia/Sleep Trouble/ _____ Hrs/Night	**OTHER**
☐ Depression/ Anxiety	☐ High Cholesterol ☐ Diabetes ☐ Heart Disease

Is this condition due to an accident? ☐Yes ☐No Type of accident: ☐Auto ☐Work ☐Home ☐Other Injury
To whom have you made a report of your accident? ☐Auto Insurance ☐Employer ☐Worker Comp ☐Other:

***If you were involved in an Auto Accident and the case is currently *open* ,**
Stop Here and notify the Front Desk for an Auto specific intake.*

Medications: Please list all medications and daily dosage (in mg), including over the counter medications.
If you are NOT taking any medications, please check this box:

☐ **I am NOT CURRENTLY taking any medications.**

Name: _____ Reason: _____ Daily Dosage (mg): _____
Name: _____ Reason: _____ Daily Dosage (mg): _____
Name: _____ Reason: _____ Daily Dosage (mg): _____
Name: _____ Reason: _____ Daily Dosage (mg): _____
Name: _____ Reason: _____ Daily Dosage (mg): _____

Medication Allergies: Please list all medication allergies below:

☐ Penicillin ☐ Sulfa Drugs ☐ Anticonvulsants ☐ Insulin
☐ Antibiotics (please specify type):_____ ☐ Other: _____
☐ I have NO KNOWN medication allergies.

Family Medical History:

☐ Heart Disease ☐ Diabetes ☐ Arthiritis ☐ Cancer: _____

☐ Other(s): _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.

2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be **loaned** to another health provider with your prior authorization only and must be returned within seven days.

Method of payment for today's charges: ☐ Cash ☐ Check ☐ Credit Card ☐ Debit Card

Acknowledgement of Notice of Privacy Practices

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.

*By signing below, I certify that all information provided on these forms is true to the best of my knowledge and that I understand and agree to the terms listed above.

x_____ _____
Signature Date