PERSONAL HISTORY for Atlas Chiropractic

Today's Date: _____/_____/_____

Name: _____ Birth Date: _____/_____/_____

Age: _____ Sex: ☐ M ☐ F SS#: _____-_____-_____ Cell #: _____-_____-_____

Address:_____ City: _____

State: _____ Zip Code: _____ Home #: _____-_____-_____

Email Address: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name: _____ Spouse's phone #: _____

Name and number of Emergency Contact: _____

Relationship: _____ Referred To This Office By: _____

CURRENT HEALTH CONDITION

What is the reason for today's visit? _____

Have you seen a doctor for this condition? ☐ NO ☐ YES Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____

Has this Condition Occurred before? ☐NO ☐YES

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other

Medications (present/past) _____

Type of Work: _____

PAST HEALTH HISTORY

Please check all that apply and describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall ☐ Bladder ☐ Hernia

☐ Back Surgery ☐ Broken Bones Other _____

Major Accident or Falls : _____

Hospitalization (other Than Above): _____

Previous Chiropractic Care: NONE ☐ Doctor's Name & Approx. Date of Last Visit: _____

Atlas Chiropractic

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Medical History

☐ Anemia	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ High Blood Pressure
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Tuberculosis
☐ Asthma	☐ German Measles	☐ Nervousness	☐ Heart Trouble
☐ Epilepsy	☐ Concussion	☐ Dizziness	☐ Digestive Disorders
☐ Diabetes	☐ Arthritis	☐ Venereal Disease	☐ Hepatitis
☐ Allergies	☐ Numbness	☐ Neuritis	☐ Backaches
☐ HIV	☐ Cancer	☐ Sinus Trouble	☐ Convulsions
☐ Rheumatism			

☐ Other: _____

Family History:

	Diabetes	Heart	Cancer	Spinal Disorder
Mother	___	___	___	___
Father	___	___	___	___
Brother, # of __	___	___	___	___
Sister, # of __	___	___	___	___

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS*:

*-Please note: you *must* check at least one area below.

Musculo-Skeletal	*Genito-Urinary*
__Low back Pain	__ Bladder Trouble
__ Pain between shoulders	__ Painful/Excessive Urination
__ Neck Pain	__ Discolored Urine
__ Arm Pain	*General*
__ Joint Pain/Stiffness	__ Fatigue
__ Walking Problems	__ Loss of Sleep
__Difficult chewing/clicking jaw	__ Headache
__ General Stiffness	

__ Other _____

Females Only

When was your last period? _____

Are you pregnant? ☐ Yes ☐ No ☐ Not Sure