Atlas Chiropractic Health Center

Date: ____________

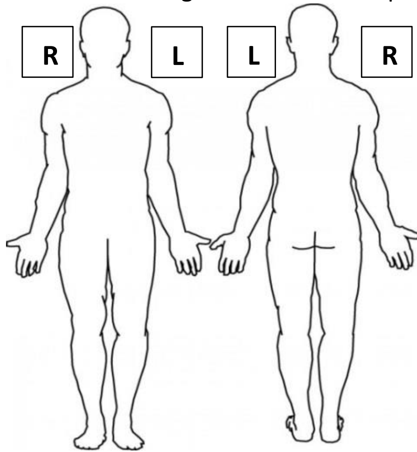
First Name: _________________________ Last Name: ___________________________________ Middle Initial: ____

MAJOR COMPLAINT INFORMATION

What is your major complaint(s)? ____
____
When did symptom(s) begin? ____
Have you experienced these symptoms before? Circle **YES** or **NO** When? ____
Are symptoms due to an *auto accident* or *work injury*? Circle **YES** or **NO**
Please circle if you have reported accident to: **Auto Insurance** or **Employer**

PAIN DIAGRAM

Using the symbols in the Pain Index, mark the areas on the diagram below where you are experiencing pain, followed by a number from 0 to 10 indicating the extent of the pain. (**0** being no pain, **10** being the worst possible pain)



PAIN INDEX

~	Spasm
Δ	Aching/Dull
*	Numbness/Tingling
#	Burning
\	Sharp/Stabbing
T	Throbbing
R	Radiating

If this is an injury, describe what happened:
____
____
____
____
____
____
____

On a scale of 0 through 10, how do you feel now? (0 being no pain, 10 being the worst pain)

0 1 2 3 4 5 6 7 8 9 10

Do you have "pins & needles" in arms or legs? If yes, please specify: ____________

What activities make symptoms worse? ___________________________________

What activities make symptoms better? ___________________________________

HEADACHES

Do you get headaches? If yes, how often? ________________________________
Nausea, vomiting, or visual disturbances? ___ yes ___ no
When was your last eye exam? ___ 1-6 mo. ___ 7-12 mo. ___ years ___ never
Abnormal blood pressure? ___ yes ___ no ___ high ___ low
Do you have jaw problems? ___ yes ___ no

Check all that apply:

Symptoms:

- ○ come & go
- ○ are constant
- ○ came on gradually
- ○ came on suddenly

Symptoms have persisted for:

- ○ days
- ○ weeks
- ○ months
- ○ years

Symptoms are worse in:

- ○ AM
- ○ midday
- ○ PM

Symptoms are better in:

- ○ AM
- ○ midday
- ○ PM

Name________________________

Atlas Chiropractic Health Center

DAILY ACTIVITIES AFFECTED BY CONDITION

Please circle all that apply:

coughing or sneezing	walking short distances	sleeping	kneeling	stooping	lying on back
bending over forward	getting out of car	climbing	pushing	gripping	dressing self
lying flat on stomach	turning over in bed	balancing	pulling	reaching	sex activity
lying on side w/ knees bent	standing > 1 hr.	sitting	holding baby	lifting	bathing
bending forward to brush teeth	carrying bag/backpack	driving	exercise	other (please specify): __________	

Have you consulted a doctor for this condition? If yes, please provide doctor's name: __________________________________

Date consulted: ___________________________ Diagnosis: ____

Does this condition interfere with your sleep? ___ yes ___ no If yes, how so?________________________________

How do you sleep? ___ On stomach ___ on back ___ on side ___ other (please explain: _____________________)

Do you sleep with a pillow? ___ yes ___ no If yes, how many? ___

Do you wear a *heel lift* or *orthotic* (circle one)? ___ yes ___ no If yes: ___ right ___ left

OTHER HEALTH HISTORY

Date of last physical exam? __________ Reason for exam? _________________ Date of most recent x-rays? _____________

List all medications you are taking now, including over-the-counter, and reason(s) for taking them:

Medicine	Dosage/Frequency	Reason for taking medicine

Please list all known allergies: ____

____

Have you ever been hospitalized or had surgery? ___ yes ___ no If yes, please list below:

Date: _________ Reason: ______________________ Date: _________ Reason: _______________________

Date: _________ Reason: ______________________ Date: _________ Reason: _______________________

Do you have a family physician? ___ yes ___ no If yes, physician's name: _______________________________

Physician's phone #: ______________________ City and state of physician's practice: _________________________________

Have you ever received chiropractic care? ___ yes ___ no If yes, date last seen: ___________________

Have you ever had a concussion? ___ yes ___ no If yes, please explain: _________________________________

____

Have you ever had any broken bones? ___ yes ___ no If yes, please explain: _________________________________

____

Have you ever had any accidents resulting in serious injury? If yes, please explain: _________________________________

____

____

Have you ever had professional clinical massage? ___ yes ___ no

Do you have a massage therapist you see regularly? ___ yes ___ no

Do you see or have you ever seen a medical specialist? ___ yes ___ no If yes, what specialty? _________________

Medical specialist's name: ________________________ City and state of specialist's practice: __________________________

How often do you exercise? ____

What type(s) of physical exercise do you enjoy or prefer? ____

Name________________________

Atlas Chiropractic
Health Center

ADDITIONAL COMPLAINTS

Check any of the following disease(s) you have or have ever had:

__ Appendicitis	__ Tuberculosis	__ Diabetes	__ Alcoholism	__ Scarlet Fever
__ Diphtheria	__ Anemia	__ Cancer	__ Addiction	__Whooping Cough
__ Heart Disease	__ Arthritis	__ Typhoid Fever	__ Measles	__ Goiter
__ Epilepsy	__ Pneumonia	__ Mumps	__ Influenza	__ Mental Disorder
__ Rheumatic Fever	__ Small Pox	__ Pleurisy	__ Lumbago	__ Polio
__ Stroke	__ Eczema	__ Malaria	__ Chicken Pox	__ Autoimmune Disease
__ Thyroid Disease	__ Osteoporosis	__ Scoliosis	__ AIDS	__ Gout

REVIEW OF SYSTEMS

Check any of the following you now have or have had in the past:

F = frequently O = occasionally N = never

Head/Ears/Eyes/Nose/Throat
__ blurred vision
__ floaters in vision
__ hearing loss
__ ringing in ears
__ loss of taste
__ loss of smell
__ glaucoma
__ ear infection
__ sinusitis
__ postnasal drip
__ nasal polyps
__ strep throat
__ Mononucleosis
__ dental issues

Cardiovascular
__ poor circulation
__ chest pain
__ shortness of breath
__ irregular blood pressure
__ irregular heart beat
__ heart problems
__ lung issues/congestion
__ varicose veins
__ ankle swelling

Integumentary
__ dry skin
__ psoriasis
__ eczema
__ acne

Respiratory
__ asthma
__ apnea
__ shortness of breath
__ emphysema
__ COPD
__ allergies
__ Pneumonia
__ Tuberculosis

Neurological
__ dizziness
__ balance difficulty
__ blurred vision
__ loss of concentration
__ depression/confusion
__ anxiety/nervousness
__ sleep disturbance
__ fatigue/energy loss
__ fainting
__ Multiple Sclerosis
__ Parkinson's
__ Fibromyalgia
__ Chronic pain
__Mood disorders
__ Other: ______________

Genitourinary
__ kidney stones
__ prostate issues
__erectile dysfunction
__ bedwetting
__ PMS symptoms
__ infertility
__ urinary tract infection
__ yeast infection
__ abnormal PAP
__ sexually transmitted disease
__ decreased libido
__ menstrual cramping
__ menstrual irregularity
__ vaginal pain

Constitutional
__ poor appetite
__ weakness
__ sudden weight change
__ fever
__ chills
__ night sweats
__ fainting
__ difficulty losing weight

Gastro-Intestinal
__ ulcer
__ anorexia/bulimia
__ food sensitivities
__ indigestion
__ unusual appetite
__ excessive thirst
__ frequent urination
__ vomiting
__ constipation
__ sudden weight change
__ hemorrhoids
__ liver issues
__ abdominal cramps
__ gas/bloating
__ heartburn
__ black bloody stool
__ diverticulitis/-osis
__ gall bladder disease
__ Ulcerative Colitis
__ Celiac
__ Crohn's disease
Irritable Bowel Syndrome

Family History
Has your: *Grandmother, Grandfather, Father, Mother, Sister, Brother, Daughter*, or *Son* **ever had:**
__ cancer
__ heart disease
__ stroke
__ arthritis
__ osteoporosis
__ high cholesterol
Other (please explain):

Y = yes
N = no

Endocrine
__ thyroid issues
__ hypoglycemia
__ low energy
__ swollen glands
__ polycystic ovarian syndrome

Musculoskeletal
__ headache
__ neck pain
__ pain between shoulders
__ arm pain/tingling/numb
__ mid back pain
__ low back pain
__ hip pain
__ leg pain/tingling/numb
__ walking problems
__ chewing difficulty

Habits:
Do you smoke? _y _n
How many per day? ____________________
Do you drink alcohol? _y _n
How much per day? ____________________
Do you consume caffeine? _y _n
How much per day: ____________________
List vitamins/supplements:
____
____
Water intake: ____________ ounces per day
How old is your bed? __________________
Sleep quality? ________________________
Rate your stress level:
- Stress free
- Low stress
- Moderate stress
- High stress
- The worst possible stress

Stress factors: *Check all that apply.*
- Relationship
- Family
- Work
- School
- Other: ______________________ __

Name________________________

Atlas Chiropractic
Health Center

EMERGENCY CONTACT

Name: ____ Relation: ______________________________
Phone: ____________________________ Is this a cell phone? _ yes _ no Work Phone: ______________________________
Address: ____ City/State/Zip: _________________________

INSURANCE INFORMATION

Insurance Company: ____ Phone: _____________________________
Address: ____ City/State/Zip: _______________________
Insured's Name: ____ Insured's SS#: _______________________
Group #: __________________________ Member ID#: _________________ Insured's Birth Date: __________________
Insured's Employer: ____

PERSONAL INFORMATION

Address: ____ City/State/Zip: _________________________
Phone: __________________________ Is this a cell phone? __ yes __ no Work Phone: ______________________________
Email: ____
Date of Birth *(mm/dd/yyyy):* __ __/__ __/__ __ __ __ Age:________ Legal Gender (for insurance use): __ female __ male
SS#: ___________________________ Driver License #: _________________________ US State of Issue: ______________
Occupation: ____________________ Circle one: *full-time* *part-time* School or Employer's Name: _____________________
Work or School City/State: _______________________

__Single __Married __Partnered __Divorced __Widowed

How were you referred to our office?
____

Optional questions:
Gender Identity: __ female __ male __ transgender __ non-binary __ other: _______________________________
My preferred pronouns are: __ she/her __ he/him __ them/they __ other: _______________________________

PLEASE READ, SIGN, AND DATE BELOW

I hereby acknowledge that the information provided above is true and accurate. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Atlas Chiropractic Health Center** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **Atlas Chiropractic Health Center** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my financial responsibility. Any dispute between legal parties shall be resolved by binding arbitration. It is not our intention to cause you undue hardship, however we must collect our receivables as efficiently as possible in order to continue our service to the community. Interest of 1% per month will be charged on delinquent accounts. If you discontinue your care, all charges are due immediately.

Patient Signature: ____ Date: ______________________________

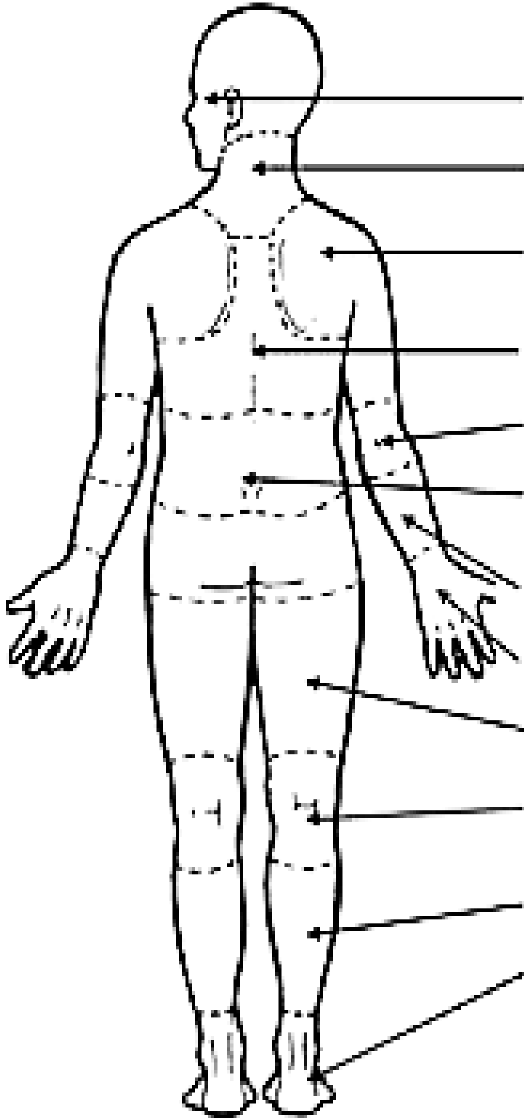
Guardian/Spouse Signature Authorizing Care: _________________________ Date: ______________________________
Printed Guardian/Spouse Full Name: ________________________________

Atlas Chiropractic
Health Center

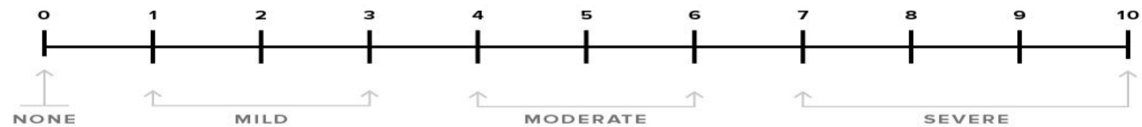
Functional Pain Index

Please check the appropriate box to let us know how you feel *TODAY*.

Patient Name: ______________________________**Date:** __________



Body Part	Right/Left	0	1	2	3	4	5	6	7	8	9	10
BODY-OVERALL												
Head												
Neck	Right/Left											
Shoulders/Chest	Right/Left											
Upper Back	Right/Left											
Elbow	Right/Left											
Lower Back	Right/Left											
Arm	Right/Left											
Wrist/Hand	Right/Left											
Pelvis/Hips	Right/Left											
Thigh	Right/Left											
Knee	Right/Left											
Lower Leg	Right/Left											
Feet/Ankle	Right/Left											



Atlas Chiropractic Health Center

LOW BACK & LEG EVALUATION

OSWESTRY Disability Index 2.0

Name:__________________________________ Age: __________Date:_______________ Score: __________

PLEASE READ: Please complete this questionnaire. It is designed to give us information as to how your **BACK (OR LEG)** trouble has affected your ability to manage in everyday life.
Please answer ***every section***. Mark one box only in each section that most closely described you ***today***.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1mile.
- ☐ Pain prevents me walking more than ¼ of a mile.
- ☐ Pain prevents me walking more than 100 yards.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.
- ☐

Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ an hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by pain.
- ☐ Because of pain, I have less than 6 hours sleep.
- ☐ Because of pain, I have less than 4 hours sleep.
- ☐ Because of pain, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 – Social Life

- ☐ My social life is normal and cause me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limitingmy more energetic interests, i.e. sports.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling

- ☐ I can travel anywhere without pain.
- ☐ I can travel anywhere but it gives extra pain.
- ☐ Pain is bad but I manage journeys of over two hours.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to receive treatment.

Atlas Chiropractic
Health Center

NECK PAIN EVALUATION

NECK PAIN DISABILITY INDEX

Name:___________________________________ Age: ___________Date:________________ Score: __________

PLEASE READ: Please complete this questionnaire. It is designed to give us information as to how your **NECK** trouble has affected your ability to manage in everyday life.
Please answer ***every section***. Mark one box only in each section that most closely described you ***today***.

Section 1 – Pain Intensity
- □ I have no pain at the moment.
- □ The pain is very mild at the moment.
- □ The pain is moderate at the moment.
- □ The pain is fairly severe at the moment.
- □ The pain is very severe at the moment.
- □ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (washing, dressing, etc.)
- □ I can look after myself normally without causing extra pain.
- □ I can look after myself normally but it is very painful.
- □ It is painful to look after myself and I am slow and careful.
- □ I need some help but manage most of my personal care.
- □ I need help every day in most aspects of self-care.
- □ I do not get dressed; I wash with difficulty, and stay in bed.

Section 3 - Lifting
- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives me extra pain.
- □ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- □ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything at all.

Section 4 – Reading
- □ I can read as much as I want with no neck pain.
- □ I can read as much as I want with slight neck pain.
- □ I can read as much as I want with moderate neck pain.
- □ I can’t read as much as I want because of moderate neck pain.
- □ I can hardly read at all because of severe pain in my neck.
- □ I cannot read at all

Section 5 – Headaches
- □ I have no headaches at all.
- □ I have slight headaches that come infrequently.
- □ I have moderate headaches that come infrequently.
- □ I have moderate headaches that come frequently.
- □ I have severe headaches that come frequently.
- □ I have headaches all the time.

Section 6 – Concentration
- □ I can concentrate fully when I want with no difficulty.
- □ I can concentrate fully when I want to with slight difficulty.
- □ I have a fair degree of difficulty concentrating when I want to.
- □ I have a lot of difficulty concentrating when I want to.
- □ I have a great deal of difficulty concentrating when I want to.
- □ I cannot concentrate at all.

Section 7 – Work
- □ I can do as much work as I want.
- □ I can only do my usual work, but no more.
- □ I can do most of my usual work, but no more.
- □ I cannot do my usual work.
- □ I can hardly do any work at all.
- □ I cannot do any work at all.

Section 8 – Driving
- □ I can drive my car without any neck pain.
- □ I can drive my car as long as I want with slight neck pain.
- □ I can drive my car as long as I want with moderate neck pain.
- □ I can’t drive my car as long as I want because of moderate neck pain.
- □ I can hardly drive at all because of severe neck pain.
- □ I can’t drive my car at all.

Section 9 – Sleeping
- □ I have no trouble sleeping.
- □ My sleep is slightly disturbed (less than 1 hour sleepless).
- □ My sleep is mildly disturbed (1 to 2 hours sleepless).
- □ My sleep is moderately disturbed (2 to 3 hours sleepless).
- □ My sleep is greatly disturbed (3 to 5 hours sleepless).
- □ My sleep is completely disturbed (5 to 7 hours sleepless).

Section 10 – Recreation
- □ I am able to engage in all of my recreation activities with no neck pain.
- □ I am able to engage in all my recreation activities with some neck pain.
- □ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- □ I am able to engage in a few of my usual recreation activities because of neck pain.
- □ I can hardly do any recreation activities because of neck pain.
- □ I can’t do any recreation activities at all because of neck pain.

1401 East Jefferson Street, Suite 501 Seattle, WA 98122 tel: 206-324-2225 fax: 206-324-5244

Atlas Chiropractic
Health Center

Auto Accident Information

Name:____________________________________Age: ___________Date:________________

Auto Accident Information

Date and time of accident: ___________________________________ ☐ AM ☐ PM

Were you the driver? ☐ Driver ☐ Front Passenger ☐ Rear Passenger
Make and Model of the vehicle you were occupying? ____
If a traffic violation was issued, to who was it issued? ____
Number of people in accident vehicle? ____________

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it / they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another Vehicle ☐ Other: _________________________________

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
If yes, please describe: ____

Make and Model of the other vehicle(s) involved? ____

Name of the location/ street on which you were traveling? ____

In which direction were you headed? ☐ North ☐ South ☐ East ☐ West

What was the approximate speed of the vehicle? ________________________

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware or ☐ surprised by the impact?

If accident vehicle made impact with another vehicle, what direction was the other vehicle headed?

☐ North ☐ South ☐ East ☐ West Approx. speed of other vehicle: __________

In your words, please describe the accident:

____

____

____

____

____

____

____

1401 E. Jefferson Street, Suite 501 Seattle, WA 98122 Tel: 206.324.2225 Fax: 206.324.5244 email: info@atlaschirohc.com

Atlas Chiropractic
Health Center

Auto Accident Information

Name:_________________________________Age: __________Date:_______________

After Injury

Did accident render you unconscious? ☐ Yes ☐ No
If yes, for how long? ________________
Please describe how you felt immediately after the accident:

____

____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/ or attending doctor:

____

Was he/she a ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Describe any treatment you received:.____

Were X-Rays taken? ☐ Yes ☐ No Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw Problems	☐ Nausea
☐ Memory Loss	☐ Irritability	☐ Arms/Shoulder Pain	☐ Back Pain
☐ Headache(s)	☐ Fatigue	☐ Numb hands/ fingers	☐ Lower Back Pain
☐ Blurred vision	☐ Tension	☐ Back Stiffness	☐ Buzzing in ear
☐ Neck Pain	☐ Chest Pain	☐ Leg Pain	☐ Ears Ringing
☐ Stiff Neck	☐ Shortness of Breath	☐ Stomach Upset	☐ Numb feet/ toes

☐ Other ____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

1401 E. Jefferson Street, Suite 501 Seattle, WA 98122 Tel: 206.324.2225 Fax: 206.324.5244 email: info@atlaschirohc.com

Atlas Chiropractic
Health Center

Auto Accident Information

Name:_______________________________________Age: ____________Date:_________________

Indicate your degree of comfort while performing the following activities:

Activity			
Lying on back	☐ Comfortable	☐ Uncomfortable	☐ Painful
Lying on side	☐ Comfortable	☐ Uncomfortable	☐ Painful
Lying on stomach	☐ Comfortable	☐ Uncomfortable	☐ Painful
Sitting	☐ Comfortable	☐ Uncomfortable	☐ Painful
Standing	☐ Comfortable	☐ Uncomfortable	☐ Painful
Stretching	☐ Comfortable	☐ Uncomfortable	☐ Painful
Lovemaking	☐ Comfortable	☐ Uncomfortable	☐ Painful
Walking	☐ Comfortable	☐ Uncomfortable	☐ Painful
Running	☐ Comfortable	☐ Uncomfortable	☐ Painful
Sports	☐ Comfortable	☐ Uncomfortable	☐ Painful
Working	☐ Comfortable	☐ Uncomfortable	☐ Painful
Lifting	☐ Comfortable	☐ Uncomfortable	☐ Painful
Bending	☐ Comfortable	☐ Uncomfortable	☐ Painful
Kneeling	☐ Comfortable	☐ Uncomfortable	☐ Painful
Pulling	☐ Comfortable	☐ Uncomfortable	☐ Painful
Reaching	☐ Comfortable	☐ Uncomfortable	☐ Painful

Have you attained an attorney? ☐ Yes ☐ No
If yes:
Name:________________________________
Address: ______________________________
Phone Number _____________________Fax:_____________________
Email:_______________________________________

Atlas Chiropractic
Health Center

Auto Accident Information

Name:____________________________________Age: ___________Date:________________

Recovery

How many hours are in your normal workday? _____________________________
Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

☐ Standing ☐ Driving ☐ Operating equipment

☐ Sitting ☐ Twisting ☐ Work with arms above head

☐ Walking ☐ Crawling ☐ Typing

☐ Lifting ☐ Bending ☐ Stooping

☐ Other ____

What positions can you work in with minimum physical effort and for how long?

____

____ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature____Date:_______/______/_______

☐ Adult patient ☐ Parent or Guardian ☐ Spouse

1401 E. Jefferson Street, Suite 501 Seattle, WA 98122 Tel: 206.324.2225 Fax: 206.324.5244 email: info@atlaschirohc.com