Atlas Chiropractic
Health Center

NEW PATIENT INTAKE

Date: _____

First Name: _____ Last Name: _____ Middle Initial: ____

MAJOR COMPLAINT INFORMATION

What is your major complaint(s)? _____

_____

When did symptom(s) begin? _____

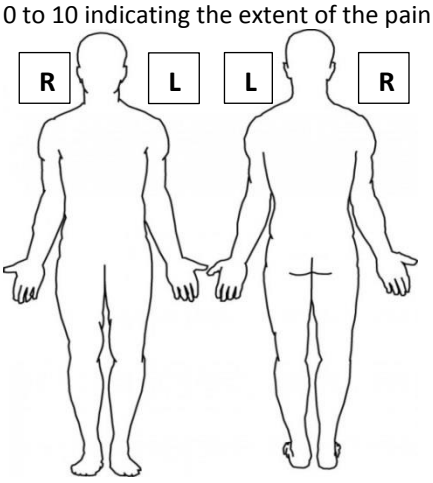
Have you experienced these symptoms before? Circle **YES** or **NO** When? _____

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

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

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

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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? _____

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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:

_____
___

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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: _____

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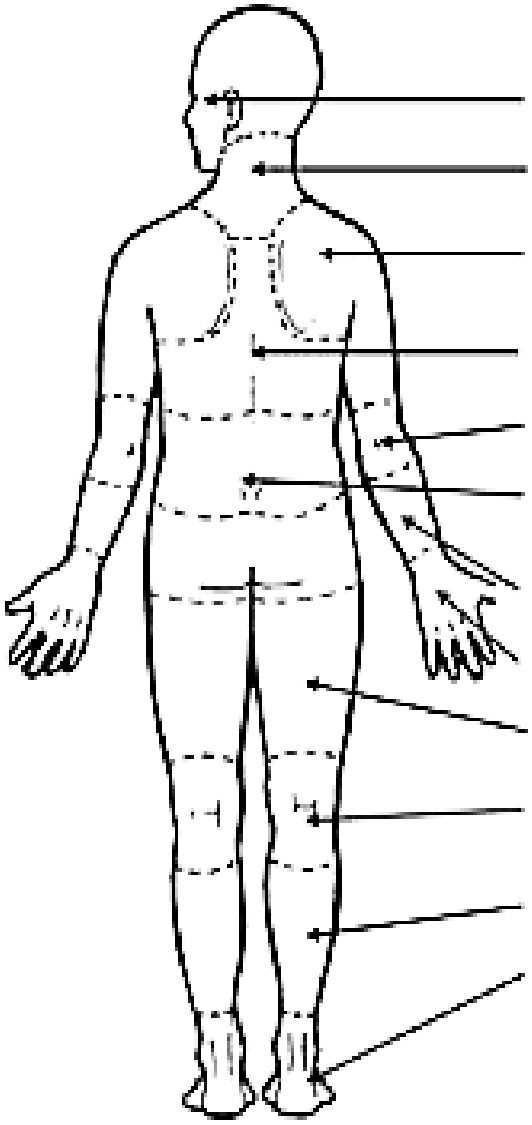
Functional Pain Index

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											

0-10 NUMERIC PAIN RATING SCALE