Atlas Chiropractic Health Center
1422 Harvard Ave.
Seattle, WA 98122
Office: 206-324-2225
FAX: 206-324-5244

Confidential Patient Information

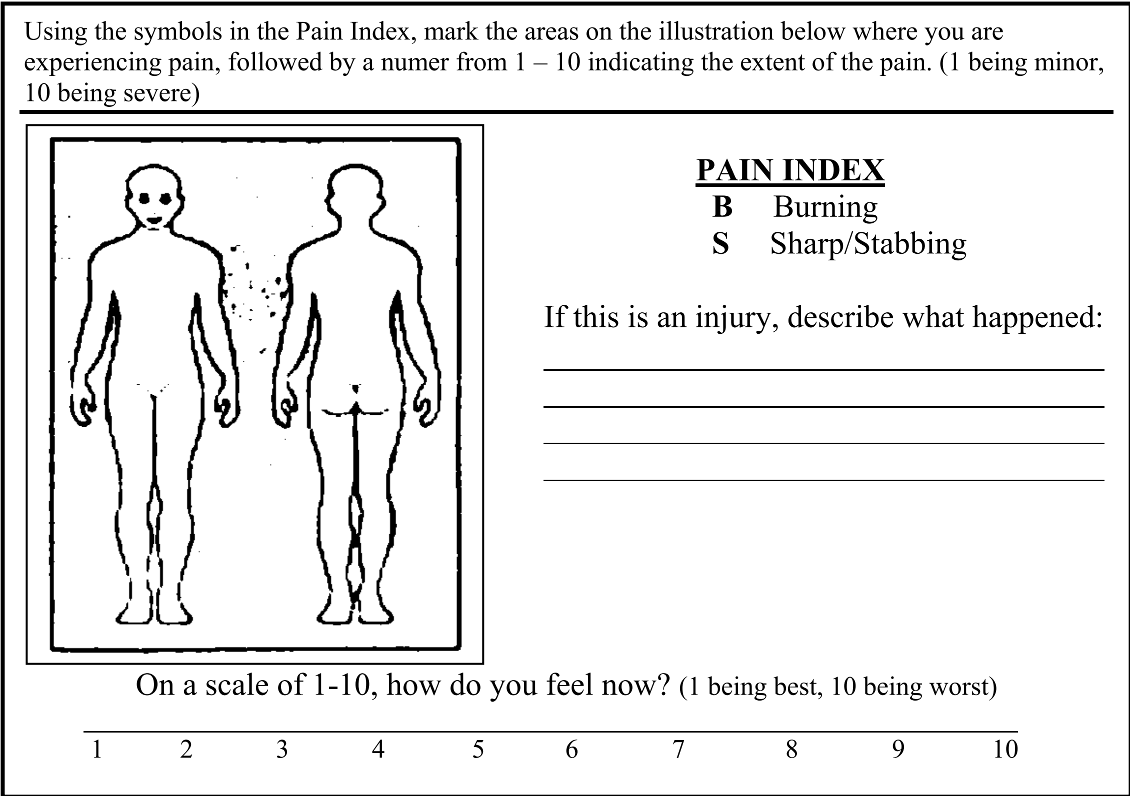
Date:___________________

First Name: _________________ Last Name:____________________ Initial: ____

MAJOR COMPLAINT INFORMATION

What is your major complaint(s)?____
____
When did symptom(s) begin? ____
Have you experienced these symptoms before? □ yes no When?______________
Are these symptoms do to auto accident or work injury? yes no
Have you reported accident to: insurance yes no employer yes no

Using the symbols in the Pain Index, mark the areas on the illustration below where you are experiencing pain, followed by a numer from 1 – 10 indicating the extent of the pain. (1 being minor, 10 being severe)



PAIN INDEX
B Burning
S Sharp/Stabbing

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

On a scale of 1-10, how do you feel now? (1 being best, 10 being worst)

1 2 3 4 5 6 7 8 9 10

Check appropriate boxes:
Symptoms: come & go came on gradually came on suddenly
Symptoms have persisted for: days weeks months years
Symptoms are worse in: AM midday PM night
Symptoms are better in: AM midday PM night
Type of pain: Dull Sharp Throbbing Burning Radiating
Do you have **Pins&Needles** in arms or legs? ___yes ___no specify:______________
What activities make symptoms worse?____
What activities make symptoms better?____
Do you ever have impairment of bowel or bladder function? ___yes ___no

INDICATE, CHECK (√) ANY DIFFICULTY TO PERFORM THE FOLLOWING ACTIVITIES

coughing or sneezing	sitting	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
walking short distances	standing > 1 hr	lying flat on side with knees bent			
bending forward to brush teeth					

Have you consulted a doctor for this condition? ___yes ___no Doctor's name:______________________
Date consulted:__________________ Diagnosis:____
Does this condition interfere with your sleep ____ yes ____no
Do you sleep on your: ____ stomach _____back ____side
Do you sleep with a pillow? ___yes ___no
Do you wear a heel lift or orthotic? (circle one)

HEADACHES

Do you get headaches? ___yes ___no How often:_____________________________________
Nausea, vomiting or visual disturbances? ___yes ___no
When was your last eye exam? ___1-6 mo. ___7-12mo. ____yrs. ___ never
Abnormal blood pressure? ___yes ___no ___high ___low
Do you have jaw problems? ___yes ___no

OTHER HEALTH HISTORY

Date of last physical exam? ___________ reason_______________ Date of most recent x-rays__________
If female, are you pregnant? ___yes ___no ___ not sure
List all medications you are taking now, including over the counter, and reason for taking them:__________
____
____
Are you allergic to any medication? ___yes ___no if yes, what____________________________________
Have you ever bee hospitalized or had surgery? ___yes ___no if yes, please list below:
________________________ Date:_____________ _______________________ Date:____________
________________________ Date:_____________ _______________________ Date:____________
Do you have a family physician? ___yes ___no Name of physician:________________________________
Phone #:_______________________ Address:____
Have you ever been to a chiropractor? ___yes ___no date last seen?_______________________________
Have you had any accidents, falls or broken bones? (anything from auto to sprained ankle)_______________
____
____

ADDITIONAL COMPLAINTS

CHECK ANY OF THE FOLLOWING DISEASE YOU HAVE HAD:

___ Appenicitis
___ Scarlet Fever
___ Diptheria
___ Thyphoid Fever
___ Pneumonia
___ Rheumatic Fever
___ Polio
___ Malaria

___ Tuberculosis
___ Whooping Cough
___ Anemia
___ Measles
___ Mumps
___ Small Pox
___ Autoimmune Disease
___ Chicken Pox

___ Diabetes
___ Cancer
___ Heart Disease
___ Goiter
___ Influenza
___ Pleurisy
___ Stroke
___ Thyroid Disease

___ Alcoholism
___ Venereal Disease
___ Arthritis
___ Epilepsy
___ Mental Disorder
___ Lumbago
___ Eczema
___ Osteoporosis

CHECK ANY OF THE FOLLOWING YOU NOW HAVE OR HAVE HAD IN THE PAST:
F = frequently O = occasionally N = never

	F O S	
MS	__ __ __	Headache
	__ __ __	Neck Pain
	__ __ __	Pain between shoulders
	__ __ __	shoulder pain
	__ __ __	arm pain/tingling/numb
	__ __ __	Mid back pain
	__ __ __	Low Back Pain
	__ __ __	Hip Pain
	__ __ __	Leg Pain/Tingling/Numb
	__ __ __	Walking Problems
	__ __ __	Difficult Chewing
NS	__ __ __	Dizziness
	__ __ __	Balance
	__ __ __	Blurred Vision
	__ __ __	Loss of Concentration
	__ __ __	Forgetfulness
	__ __ __	Stress
	__ __ __	Depression/Confusion
	__ __ __	Anxiety/Nevousness
	__ __ __	Sleep Disturbance
	__ __ __	Energy Loss/Fatigue
	__ __ __	Buzzing/Ringing in Ears
	__ __ __	Fainting
	__ __ __	Palpitations
GI	__ __ __	Indigestion
	__ __ __	Poor/Excessive Appetite
	__ __ __	Excessive Thirst
	__ __ __	Frequent Urination
	__ __ __	Vomiting
	__ __ __	Constipation
	__ __ __	Sudden changes in weight in past 6 months

	F O S	
	__ __ __	Hemorrhoids
	__ __ __	Liver Trouble
	__ __ __	Gall Bladder Problems
	__ __ __	Weight Trouble
	__ __ __	Abdominal Cramps
	__ __ __	Gas/Bloating after meals
	__ __ __	Heartburn
	__ __ __	Black Bloody Stool
	__ __ __	Colitis
GU	__ __ __	Kidney/Bladder Trouble
	__ __ __	Painful Excessive Urination
	__ __ __	Discolored Urine
CVR	__ __ __	Poor Circulation
	__ __ __	Chest Pain
	__ __ __	Short Breath
	__ __ __	Blood Pressure Problems
	__ __ __	Irregular Heart Beat
	__ __ __	Heart Problems
	__ __ __	Lung Problems/Congestion
	__ __ __	Varicose Veins
	__ __ __	Ankle Swelling
ENT	__ __ __	Vision Problems
	__ __ __	Dental Problems
	__ __ __	Sore Throat
	__ __ __	Fever
	__ __ __	Ear Aches
	__ __ __	Hearing Difficulty
	__ __ __	Allergy
	__ __ __	Bloody Nose

<u>Family History</u>:

	Y	N
Cancer	__	__
Heart Disease	__	__
Stroke	__	__
Diabetes	__	__
Arthritis	__	__
Osteoporosis	__	__
High Cholesterol	__	__

<u>Habits:</u>

Do you smoke __ __
How much _____/day
Alcohol_____________
Vitamins____________
____
How old is the bed you sleep in?_______

<u>Female</u>

Menstral Irreg. __ __
Menstral Cramp __ __
Vaginal Pain __ __
Breast Pain/lump __ __
Sex. Trans. Dis. __ __
Are you pregnant __ __

<u>Male</u>

Prostate dysfunct. __ __
Sexual Dysfunct. __ __
Sex. Trans. Dis. __ __
Trouble Urinating __ __

EMERGENCY CONTACT

Name:____ Relation:____________________________
Home Phone: ____________________________ Work Phone: _____________________________________
Address: ____
City/State/Zip: ____

INSURANCE INFORMATION

Insurance Company: ____ Phone#:_______________________
Address: ____
City/State/Zip: ____
Insured's Name: _____________________________________ Insured's SS# _________________________
Group #: _____________________________ Insured's Birth Date:__________________________________
Insured's Employer: ____

PERSONAL INFORMATION

Address: ____
City/State/Zip: ____
Home Phone: _____________________________ Work Place: ____________________________________
Cell Phone: ______________________________ email: ____
SS#: __________________________ Date of Birth: __________________ Age: ________ M___ F___
Drivers License #: _____________________________________
Marital Status: ___S ___M ___D ___W Spouse's name: _______________________________________
Occupation:_________________________ Employer's Name: _____________________________________
Work Address: ____
City/State/Zip: ____
How were you referred to our office? ____

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 renders me are charges directly to me and that I am personally responsible for payment. Any accounts that are referred for collection will have a service fee charged at the time of referral to cover additional handling costs. Should legal action be necessary for the recovery of any monies due under this agreement, the prevailing party shall be entitled to recover attorney fees and court costs from the other party. Any disputed between 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 account. If you discontinue your care, all charges are due and payable immediately.

Patient's Signature:____ Date:_____________________
Soc Sec. #:_________________________ Driver's License#______________________________________
Guardian or Spouses" Signature Authorizing Care:____