ATLAS CHIROPRACTIC CARE
2322 Clover Street
Rochester, NY 14618

## 1. Patient Information

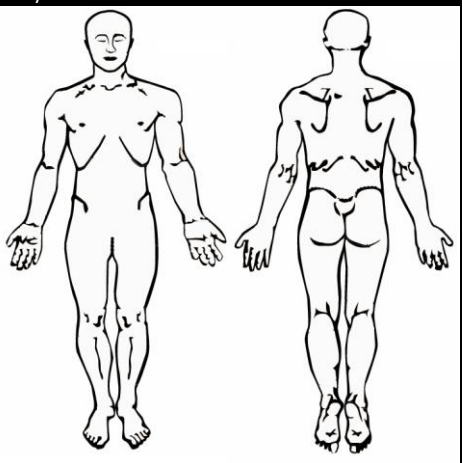
Legal Name: (First)_____ (M.I.) _____ (Last) _____
Gender: □ Male □ Female Age:_____ Social Security #:_____ DOB:____/____/_____
Address: (Street)_____ (City)_____ (State)_____ (Zip)_____
Primary Phone:_____ □ Home □ Cell □ Work Height:_____ft.____in. Weight:_____lbs.
Marital Status: □Single □Married □Partnered □Widowed □Divorced Spouses Name:_____
Number of children_____ Email:_____**We will not disclose your email to any third parties
Occupation:_____ Patient Employer/School:_____
Emergency Contact: (Name)_____ (Relationship)_____ (Phone)_____
Whom may we thank for referring you? Event attended?_____
Do you give the office permission to text you? □ YES □ NO Do you wear orthotics/heel lifts? □Yes □No

## 2. Primary Complaint

Please note ONE complaint in the following section. This is your chief complaint or most problematic concern at this time that brings you in today.

□**Denied**

Primary complaint:_____
How long have you had these symptoms?:_____
What do you think caused the problem?:_____
Most recent occurrence date:_____
Do activities make it better, worse or no change?_____
The condition is getting □Worse □Better □No Change □Unknown
Rate severity of pain… at its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
… at its least severe: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
… at present moment: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
Type of pain: □ **Sharp** □ **Dull** □ **Throbbing** □ **Numbness** □ **Aching** □ **Shooting**
□ **Burning** □ **Tingling** □ **Cramps** □ **Stiffness** □ **Swelling** □ **Other:**_____
Does the pain travel from one location to another? From where to where?_____
Pain worsens with:_____
Pain improves with:_____



How often does this occur? □Constantly □ Comes and goes □ Infrequently □ Daily □ Weekly □Monthly
Which activities are affected by this? □ Daily Routine □ Recreation □ Sleep □ Work □ N/A □ Other:_____
□ Sitting □ Standing □ Walking □ Bending □ Lying Down
Past Treatments:_____ Was it successful? □ Yes □ No
Additional Comments:_____

## 3. Additional Complaint II

□**Denied**

Complaint:_____
Please describe condition:_____
How long have you had these symptoms?:_____
How often does it occur?:_____
Do activities make it better, worse, or no change?:_____
Rate severity of pain at its present moment: *(least pain)* 0 1 2 3 4 5 6 7 8 9 10 *(severe pain)*
Type of pain: □ **Sharp** □ **Dull** □ **Throbbing** □ **Numbness** □ **Aching** □ **Shooting**
□ **Burning** □ **Tingling** □ **Cramps** □ **Stiffness** □ **Swelling** □ **Other:**_____
Does the pain travel from one location to another? From where to where?_____
Which activities are affected by this? □ Daily Routine □ Recreation □ Sleep □ Work □ N/A □ Other:_____
□ Sitting □ Standing □ Walking □ Bending □ Lying Down
Past Treatments:_____ Was it successful? □ Yes □ No
Additional Comments:_____



Provider Name:_____ Provider Signature:_____ Date:_____

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## 4. Additional Complaint III □Denied

Complaint:_____
Please describe condition:_____
How long have you had these symptoms?:_____
How often does it occur?:_____
Do activities make it better, worse, or no change?:_____
Rate severity of pain at its present moment: *(least pain)* 0 1 2 3 4 5 6 7 8 9 10 *(severe pain)*
Type of pain: □ **Sharp** □ **Dull** □ **Throbbing** □ **Numbness** □ **Aching** □ **Shooting**
□ **Burning** □ **Tingling** □ **Cramps** □ **Stiffness** □ **Swelling** □ **Other:**_____
Does the pain travel from one location to another? From where to where?_____
Which activities are affected by this? □ Daily Routine □ Recreation □ Sleep □ Work □ N/A □ Other:_____
□ Sitting □ Standing □ Walking □ Bending □ Lying Down
Past Treatments:_____ Was it successful? □ Yes □ No
Additional Comments:_____

## 5. Medical History

**Name and address of other doctor(s):**_____
_____
**Date of last:** Physical Exam:_____ X-Ray:_____ Spinal Exam:_____
MRI/CT/Bone Scan:_____ Blood Test:_____ Urine Test:_____

**Please circle to indicate whether you have experienced/are experiencing each of the following:**

| | | | | |
|---|---|---|---|---|
| Headaches | Neck pain | Jaw pain | Clotting Disorders | Pneumonia |
| Shooting head pains | Upper back pain | Ear infections/pain | Chicken Pox | Rhuem. Arthritis |
| Sinus trouble | Shoulder pain | **Herniated Disk** | Alcoholism | Osteoperosis |
| Loss of taste/smell | Mid back pain | Hip pain | Hepatitis | **Stroke** |
| Migraines | Lower back pain | Carpal tunnel syndrome | Liver disease | Ulcers |
| Throat troubles | Buttock pain | Multiple Sclerosis | Kidney disease | Psychiatric care |
| Thyroid trouble | Loss of balance | Cancer | Asthma | Chicken Pox |
| Sleeping trouble | Ringing in the ears | Anemia | Heart disease | Pacemaker |
| Facial pain or palsy | Hearing difficulty | Appendicitis | Eating disorders | Heart palpitations |
| Loss of memory | Vision trouble | Mononucleosis | Diabetes | High blood pressure |
| Chronic fatigue | Pins and needles in arms/hands | | HIV/AIDS | Low blood pressure |
| Depression/anxiety | Chest or rib pains | Autoimmune disease | Parkinson's | Fibromyalgia |
| Stress | Shortness of breath | **Bleeding Disorders** | Tremors | |
| Dizziness/vertigo | Fainting or seizures | Arthritis | Pinched nerve | |

Other:_____

## 6. Medications Vitamins/Supplements Allergies

| Medications | Vitamins/Supplements | Allergies |
|---|---|---|
| 1)_____ | 1)_____ | 1)_____ |
| 2)_____ | 2)_____ | 2)_____ |
| 3)_____ | 3)_____ | 3)_____ |
| □None | □None | □None |

Other:_____

## 7. Family History

| | | | | | |
|---|---|---|---|---|---|
| Autoimmune Dis. | □ Yes □ No | Diabetes | □ Yes □ No | Migraines | □ Yes □ No |
| Bleeding Disorder | □ Yes □ No | Heart Disease | □ Yes □ No | Osteoperosis | □ Yes □ No |
| Clotting Disorder | □ Yes □ No | High Blood Pressure | □ Yes □ No | Stroke | □ Yes □ No |
| Cancer | □ Yes □ No | Kidney Disease | □ Yes □ No | Thyroid Disease | □ Yes □ No□ |

□ Other:_____

Provider Name:_____ Provider Signature:_____ Date:_____

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**8. Is there anything else you would like the Doctor to know?**

_____

_____

**Please read and initial to each agreement:**

**_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters or emails with general health information.**

**_____ I understand that X-Rays may be hazardous to an unborn child and I attest, to the best of my knowledge that I am not pregnant. Date of last menstrual cycle_____**

**_____ To the best of my knowledge, I attest that the information supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concerns.**

## FOR OFFICE USE ONLY

**Clinical Comments:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

_____

If patient is a Minor- Guardian Signature



Provider Name:_____ Provider Signature:_____ Date:_____