Atlas Health Solutions / Thomas D. Kleinman, D.C.
1339 East Ocean Blvd., Stuart, FL

First Name ____________________ Last Name ____________________

Birthdate ____________ Age ______ Sex ______ Marital Status S/M/W/D SS# ____________

Address ____________________ City ____________ St ______ Zip ______

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Email ____________________ Referred By ____________________

Occupation ____________________ Employer ____________________

Goal in consulting with the Doctor: _____ Temporary Relief _____ Lasting Correction _____ Let Dr. recommend best type of care

General Practitioner ____________________ Specialists ____________________

Major Complaint ____

What caused it? How did it start ____

How long have you had these symptoms ____________ Percent of time with these symptoms ____________

Have you had a similar condition in the past ____________ Are symptoms getting worse ____________

Current Medications ____

Describe the symptoms at their worst ____

Does anything alleviate the symptoms ____

Difficulty in performing basic daily activities: (check all that apply) ___ bathing/showering ___ shaving ___ dressing ___ cleaning

Other ____

Work: ______ I just get through ______ slower production due to pain ______ cannot work at all _____ Other ____________

Activities that have become difficult or you cannot do ____

Other doctors seen for these symptoms ____

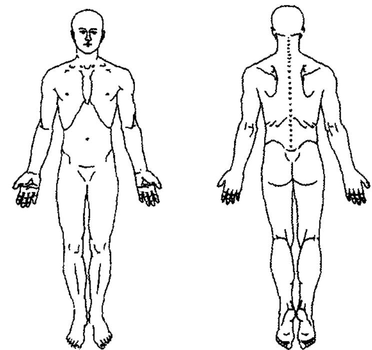
Mark any of the following symptoms you experience, current (C) or past (P).

___ Neck Problems
___ Headaches
___ Shoulder Problems
___ Arm Problems
___ Numb arms/fingers
___ Pain between shoulders
___ Low back problems
___ Leg problems
___ Numb legs/toes
___ Loss of feeling
___ Stiff joints
___ Painful joints
___ Muscle cramps

___ Dizziness
___ Memory Problems
___ Mental/Emotion
___ Depression
___ Anxiety
___ Insomnia/Fatigue
___ Vision problem
___ Ear Infection
___ Walking problem
___ Hearing loss
___ Frequent colds
___ Diarrhea
___ Diabetes

___ Allergies
___ Hay Fever
___ Asthma
___ Heart Problems (Angina, MI, CAD, COPD, CHF)
___ Blood Pressure H/L
___ Kidney Problem
___ Ulcers
___ Indigestion or Nausea
___ Eczema
___ Constipation
___ Broken bones
___ Menstrual cramps

Circle any areas of pain



Rate the severity of our pain 0-10 ________ Have you had surgery or been hospitalized ____________________

When did you last see a chiropractor? Name ? ____________________ Date of last spinal x-ray ____________

Family History: List any conditions affecting your family ____

Is there any chance you are pregnant at this time ____________

ADL: ______ Restricts daily activities ______ Restricts regular exercise ______ Difficulty walking/standing/sitting ______ Other

Trauma from birth to present: Injuries/Falls/Car or Bike Accidents/Other ____________________

____

I give Atlas Health Solutions and its representatives, permission to communicate to me via the contact information above.

Signature ____________________ Date ____________________