Atlas Chiropractic of Palm City

First Name _____ Last Name _____ Middle _____

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 _____

2. Work: ____ I just get through ____ slower production due to pain ____ cannot work at all ____ Other _____

3. Activities that have become difficult or you cannot do _____

Other doctors seen for these symptoms _____

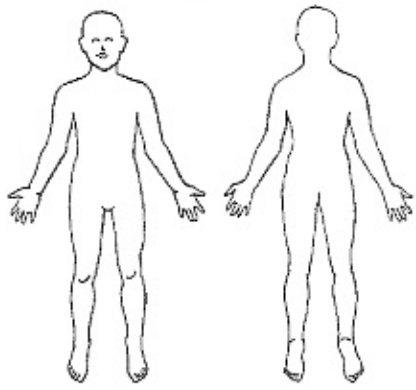
Mark any of the following symptoms you experience, current (C) or past (P).

_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
_Anixiety
_Insomnia/Fatigue
_Vision problem
_Ear infectioin
_Walking problem
_Hearing loss
_Frequent Colds
_Diarrhea
_Diabetes

_Allergies
_Hay Fever
_Asthma
_Heart problems
(Angia, MI, CAD, COPD, CHF)
_Blood Pressure H/L
_Kidney Problem
_Uclers
_Indegestion or Nausea
_Eczema
_Constipation
_Broken Bones
_Menstrual Cramps

Circle any areas of pain



Rate the severity of your pain 0-10 _____ Have you had surgery of 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 _____

_____

Signature _____ Date _____