

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Gender

Male Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status

Single Married Divorced

Widowed Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

Yes No

Preferred method of contact?

Home Phone Cell Phone

Work Phone Email

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self Spouse Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

I certify that any changes to my personal information have been updated above for your records.

Signature

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11. Social History (Tell Dr. Winn about your health habits and stress levels.)

Alcohol use Daily Weekly How much? _____
 Coffee use Daily Weekly How much? _____
 Tobacco use Daily Weekly How much? _____
 Exercising Daily Weekly How much? _____
 Pain relievers Daily Weekly How much? _____
 Soft drinks Daily Weekly How much? _____
 Water intake Daily Weekly How much? _____
 Hobbies: _____

Prayer or meditation? Yes No
 Job pressure/stress? Yes No
 Financial peace? Yes No
 Vaccinated? Yes No
 Mercury fillings? Yes No
 Recreational drugs? Yes No

Patient name _____

12. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. Is there anything else Dr. Winn should know about your current condition, your progress or ways your current condition is affecting your life?

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Consultation Notes

Doctor's Initials _____

**Atlas Chiropractic, Massage
and Wellness Center
Dr. Andrew Winn D.C.**

Signature _____

Date (MM/DD/YYYY) _____