ATLAS
CHIROPRACTIC CARE

1580 Elmwood Ave. Suite 1C
Rochester, NY 14620

1. Patient Information

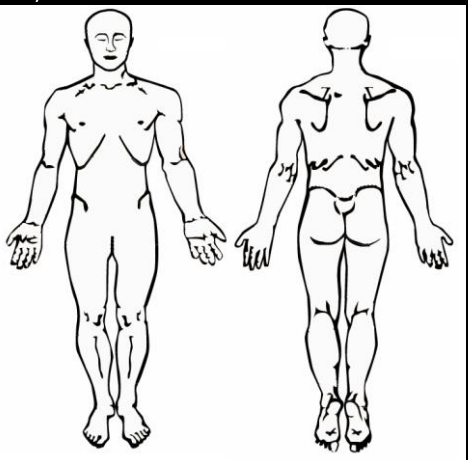
Legal Name: (First)_____ (M.I.) _____ (Last) _____
Gender: □ Male □ Female Age:_____ DOB:____/____/_____
Address: (Street)_____ (City)_____ (State)_____ (Zip)_____
Primary Phone:_____ □ Home □ Cell □ Work Height:_____ft.____in. Weight:_____lbs.
Marital Status: □Single □Married □Partnered □Widowed □Divorced 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.

☐ **No Complaints**

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 it's worst: *(least pain)* 0 1 2 3 4 5 6 7 8 9 10 *(severe pain)*
when it's 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

☐ **No Complaints**

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. 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	**Scoliosis**	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	Arthritis	**Stroke**
Migraines	Lower back pain	Carpal tunnel syndrome	Liver disease	**Cancer**
Throat troubles	Buttock pain	Loss of Balance	Kidney disease	Psychiatric care
Thyroid trouble	Sciatica	Ringing in the ears	Asthma	Multiple Sclerosis
Sleeping trouble	Numbness/Pain in legs	Hearing difficulty	Heart disease	Pacemaker
Facial pain or palsy	Hip pain	Appendicitis	Eating disorders	Heart palpitations
Loss of memory	Pinched Nerve	Mononucleosis	Diabetes	High blood pressure
Chronic fatigue	Pins and needles in arms/hands		Anemia	Low blood pressure
Jaw pains	Chest or rib pains	Autoimmune disease	Parkinson's	Fibromyalgia
Stress	Shortness of breath	**Bleeding Disorders**	Tremors	□ Other_____
Dizziness/vertigo	Fainting or seizures	Depression/anxiety		_____

Date(s) of any previous surgeries:_____

_____

5. Medications / Vitamins/Supplements / Allergies

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

6. 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:_____

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

_____

_____

_____

_____

Provider Name:_____ Provider Signature:_____ Date:_____

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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:_____