NEW MEMBER PAPERWORK

Name: _____ Date: _____

E-mail Address: _____ ☐ check box to NOT receive our newsletter.

Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____

Physical Address: _____ Mailing: _____

City/State/Zip: _____ Marital Status: S M W D

Gender: _____ Age: _____ Birthday: _____ # Of Children: _____

Name Of Your Employer: _____ Occupation: _____

Name Of Significant Other: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship To Member: _____

MEDICAL HISTORY

Main Symptoms & Severity (0-10 Scale)	Date Symptom Started	Duration of Symptom
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

How are these symptoms affecting the things most important in your life?

1. _____

2. _____

3. _____

Were you injured on the job / auto accident? YES NO

Have you missed any days from work or school? Dates: _____

What, if anything, makes it feel better? _____ Worse? _____

What other doctors did you consult for this condition? (Names & Dates): _____

Their Diagnosis: _____ Results: _____

Please list any past accidents or falls: _____

Please list any broken bones/fractures: _____

Have you had any surgeries/hospitalizations? _____

Date of Last Physical Exam: _____ Date of Last Chiropractic Exam: _____

Height: _____ Weight: _____

Are you pregnant? YES NO

Who can we thank for referring you? _____

ATLAS
CHIROPRACTIC
innate healing center

PLEASE FILL OUT ALL AREAS

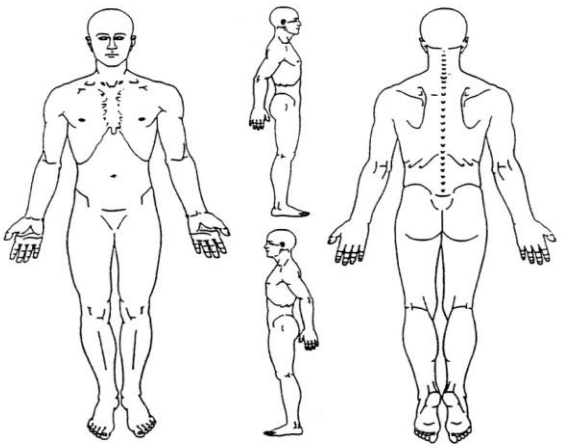
List any imaging of your spine (X-Rays/MRI/CT scans) _____

Where you received these images: _____

***PLEASE BRING THESE WITH YOU TO YOUR NEXT APPOINTMENT SO WE CAN BETTER TO ASSIST YOU.**

Please annotate "C" for current or "P" for past that you are or have experienced.

SYMPTOMS:	SELF	SPOUSE	CHILD 1	CHILD 2	SYMPTOMS:	SELF	SPOUSE	CHILD 1	CHILD 2	SYMPTOMS:	SELF	SPOUSE	CHILD 1	CHILD 2
NECK PAIN					VISION/EYE TROUBLE					COLD HANDS				
HEADACHE					NERVOUSNESS/ANXIETY					COLD SWEATS				
ARM PAIN					DEPRESSION					ARTHRITIS				
ARM NUMBNESS					NOSE BLEEDS					ANEMIA				
GOUT					SINUS TROUBLE					HOT FLASHES				
CHEST PAIN					DIFFICULTY SWALLOWING					MENSTRUAL PAIN / IRREGULARITY				
LOW BACKACHES					DIABETES					SLEEPWALK OR TALK				
MID BACKACHES					BITE TONGUE/CHEEK					THYROID ISSUES (HYPER/HYPO)				
LEG PAIN					ALLERGIES					PAIN BETWEEN SHOULDERS				
LEG NUMBNESS / TINGLING					ASTHMA					HEART TROUBLE				
SCIATICA					ADHD					LOW BLOOD PRESSURE				
JOINT SWELLING					BED WETTING					HIGH BLOOD PRESSURE				
LOSS OF APPETITE					FAINTING					LUMPS IN BREAST / CHEST				
LOSS OF SMELL					FEVER					CANCER				
LOSS OF TASTE					FOOD ALLERGIES					HAND NUMBNESS / TINGLING				
DIZZINESS					ULCERS					FIBROMYALGIA				
NAUSEA					COLITIS					MULTIPLE SCLEROSIS				
BUZZING/RINGING IN EARS					DIARRHEA					TREMORS				
PLUGGED EARS					POLIO					IRRITABLE BOWEL SYNDROME				
LIGHT SENSITIVITY					BRAIN FOG					CEREBRAL PALSY				
IRRITABILITY					CONSTIPATION					SLEEPING PROBLEMS / RESTLESS				
CLUMSINESS					HEMORRHOIDS					NIGHTMARES / NIGHT TERRORS				
FATIGUE / TIRED					FREQUENT URINATION					SKIN CONDITIONS				
C-SECTION / VACUUM @ BIRTH					WISDOM TEETH EXTRACTION					LIGAMENT LAXITY				



PAIN CHART:

-Please write the **number(s)** on the body drawing that most closely describes the sensations you feel.

-Use **arrows** to show radiating pain or odd sensations.

Fill this out very accurately.

1 = Numbness
2 = Tingling
3 = Burning
4 = Ache
5 = Sharp
6 = Throbbing
7 = Stabbing
8 = Pins & Needles

SIGNATURE: _____

DATE: _____

LIFESTYLE

It has been shown that **daily lifestyle stress significantly impacts your overall health & well-being**. As a family wellness office, we specialize in not only removing the cause of your health challenges, but we also focus on teaching you how to manage the lifestyle stresses that are keeping you from reaching your optimum health & wellness.

Please Rate the Following & Check All Answers That Apply to Your Habits:

Eating Habits:

- □ I eat 3-5 times a day.
- □ I eat fruits & vegetables daily.
- □ I eat out 2-3 times a week (min).
- □ I crave sweets.
- □ I don't watch what I eat.

Exercise Habits:

- □ I exercise 3-5 times a week.
- □ I walk daily.
- □ I don't exercise.
- □ I want to exercise.
- □ I sit for 5+ hours a day.

Sleep:

- □ I sleep 7-9 hours a night.
- □ I wake up well rested.
- □ I wake up tired.
- □ I toss & turn.
- □ I stay up late.

Mind Set:

- □ I have a positive outlook.
- □ I have a negative outlook.
- □ I am always in a good mood.
- □ I am always in a bad mood.
- □ I trap things inside.
- □ I share easily.

General Health:

- □ I am not on medications.
- □ I take care of myself.
- □ I base my health on how everyone around me is doing.
- □ I think I am healthy but know I could make some changes.

On A Scale Of 1-10 Describe Your Psychological/Emotional Stress Levels: (0 = None / 10 = Extreme)

Occupational: _____

Personal: _____

Overall Health: _____

Check The Following That Apply: ☐ Tobacco ☐ Alcohol ☐ Coffee ☐ Drugs ☐ Overeating ☐ Soda

List Any Vitamins/ Supplements You Are Currently Taking: _____

What Medications Are You Taking? (If Any) _____

At our office we pride ourselves in helping you to achieve phenomenal results with your health and wellness. For us to truly help you to be as healthy as possible, it is important that we understand your goals for your overall health & well-being.

Please list your goals for your health & wellness in the spaces provided:

PHYSICAL GOALS	NUTRITIONAL GOALS	PSYCHOLOGICAL GOALS

COMMENTS: _____

_____

_____