WELCOME TO ATLAS CHIROPRACTIC
PLEASE FILL OUT THE FOLLOWING INFORMATION:

NAME____ DATE__________________ BIRTH DATE_______________ S.S.#________________

ADDRESS__________________________________CITY\STATE_____________________________ZIP__________ PHONE #(___)__________________

W. PHONE (___)__________________ CELL PHONE(___)__________________ E-MAIL ADDRESS _______________________________________

HOW WOULD YOU LIKE YOUR REMINDERS: TEXT OR EMAIL (*CIRCLE ONE*) WHO IS YOUR CELL PHONE PROVIDER_____________________

MARITAL STATUS: S M W D # OF CHILDREN_______ OCCUPATION_____________________ EMPLOYER________________________________

EMERGENCY CONTACT__________________________________ RELATONSHIP_____________________ PHONE #___________________________

HOW DID YOU HEAR ABOUT THIS CLINIC?____________________________ HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? ____________

HEIGHT ___________ WEIGHT __________ MOST RECENT BLOOD PRESSURE __________ DO YOU SMOKE? ___________________________

SYMPTOMS CAUSING YOU TO SEEK TREATMENT: ____

IS PAIN SHARP, DULL, THROBBING OR OTHER: ____

RATE PAIN WITH "10" AS SEVERE AND "0"AS NO PAIN :____

ALLERGIES TO MEDICATIONS: ____

HOW DID THIS PROBLEM START (DESCRIBE TRAUMA): ____

____

WHAT MAKES SYMPTOMS WORSE? ____

WHAT MAKES SYMPTOMS BETTER? ____

DOES YOUR PAIN RADIATE INTO ARMS OR LEGS? ____________________ PERCENT OF TIME PROBLEMS EXISTS: _______________________

WHAT OTHER TREATMENT HAVE YOU HAD FOR THIS PROBLEM? ____

____

MEDICATIONS (names and dosage):____

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DOCTORS NOTES

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PRE SCANNING PALPATION ------- PRE LEG LENGTH R / L _________