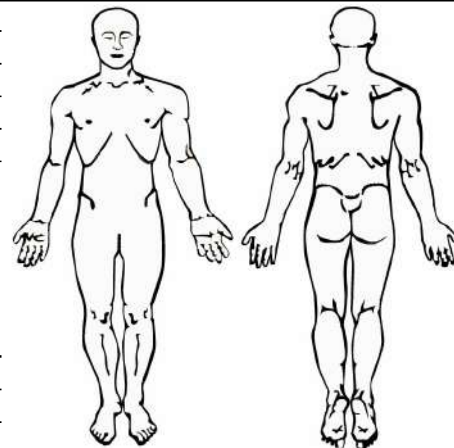
ATLAS CHIROPRACTIC CARE
2322 Clover Street
Rochester, NY 14618

1. Patient Information

Legal Name: (First)_______________________________ (M.I.) ________ (Last) ___________________________________
Gender: □ Male □ Female Age:________ Social Security #:__________________ 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. **□Denied**



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 its worst: (least pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)
… at its 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

□Denied

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:____________

2322 Clover Street
Rochester, NY 14618

4. Additional Complaint III ☐Denied

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:

5. 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	Jaw pain	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	Hepatitis	**Stroke**
Migraines	Lower back pain	Carpal tunnel syndrome	Liver disease	Ulcers
Throat troubles	Buttock pain	Multiple Sclerosis	Kidney disease	Psychiatric care
Thyroid trouble	Loss of balance	Cancer	Asthma	Chicken Pox
Sleeping trouble	Ringing in the ears	Anemia	Heart disease	Pacemaker
Facial pain or palsy	Hearing difficulty	Appendicitis	Eating disorders	Heart palpitations
Loss of memory	Vision trouble	Mononucleosis	Diabetes	High blood pressure
Chronic fatigue	Pins and needles in arms/hands		HIV/AIDS	Low blood pressure
Depression/anxiety	Chest or rib pains	Autoimmune disease	Parkinson's	Fibromyalgia
Stress	Shortness of breath	**Bleeding Disorders**	Tremors	
Dizziness/vertigo	Fainting or seizures	Arthritis	Pinched nerve	

Other:____________________

6. Medications / Vitamins/Supplements / Allergies

Medications	Vitamins/Supplements	Allergies
1)________	1)________	1)________
2)________	2)________	2)________
3)________	3)________	3)________
☐None	☐None	☐None

Other:____________________

7. 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:____________________

Provider Name:____________ Provider Signature:____________ Date:________

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

____

____

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

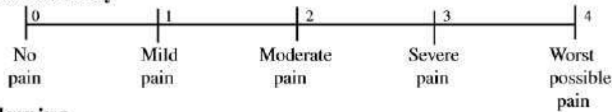
Provider Name:__________________________ Provider Signature:__________________________ Date:____________

Functional Rating Index

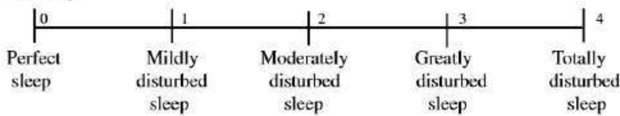
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

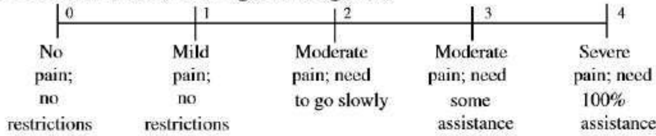
1. Pain Intensity



2. Sleeping

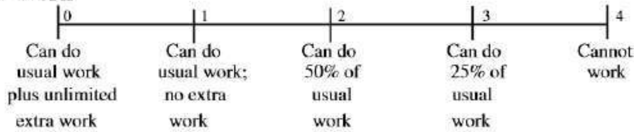


3. Personal Care (washing, dressing, etc.)

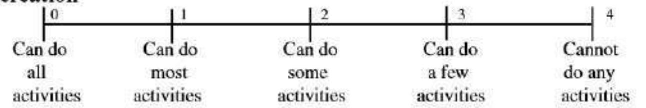


4. Travel (driving, etc.)

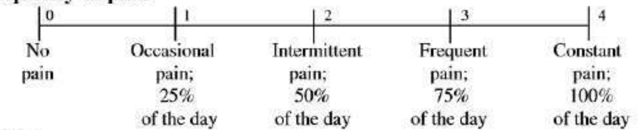
5. Work



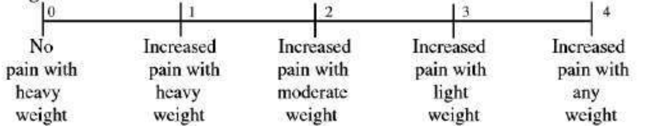
6. Recreation



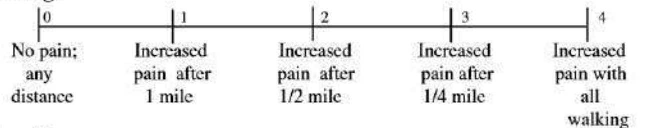
7. Frequency of pain



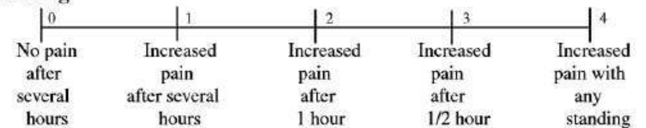
8. Lifting



9. Walking



10. Standing



Name ______________________________

PRINTED

____

Signature

____

Date

Total Score ____________

© Institute of Evidence-Based Chiropractic
www.chiroevidence.com