Patient Personal Injury Information:

Date_____

Patient Name_____

Date of Birth_____ Sex: Male___ Female____

Patient SSN: _____ Do you rent ___ Own___

Address_____

City_____ State_____ Zip: _____

Cell Phone #_____ _____Home #_____

Email: _____

Occupation: _____

Employer/School: _____

Address Employer/School_____

City _____State _____Zip_____

Employer/school Phone#_____

____Married ____Single ____Widowed ____Divorced ____

Separated____ ____other

Spouse's Name_____

Do you have children ____ yes ____No how many_____

How did you hear about us? _____

Health Insurance Information .

Policy Name_____

Insurance Company _____

Policy #_____ Group#_____

Relationship to patient ___self __spouse __Child ___Other

Policy Holder's Date of birth: _____

City _____State _____Zip_____

Employer Phone_____

Emergency Contact .

Note: this must be someone NOT living in your house hold.

Name: _____Relationship_____

Cell Phone: _____ Work Phone_____

Patient Condition .

Please indicate any other symptoms that you have experienced:

___Dizziness ___Memory Loss ___Headaches ___Numb feet/toes

___Irritability ___Ear Ringing ___Back Pain ___Difficulty Sleeping

___Fatigue ___Jaw Problems ___Chest Pain ___Arm/Shoulder Pain

___Leg Pain ___Back Stiffness ___Blurred Vision ___Numb Hand/Finger

___Tension ___Low Back Pain ___Neck Stiffness ___Shortness of Breath

___Nausea ___Buzzing In Ear ___Neck Pain ___Digestive Troubles

___Other_____

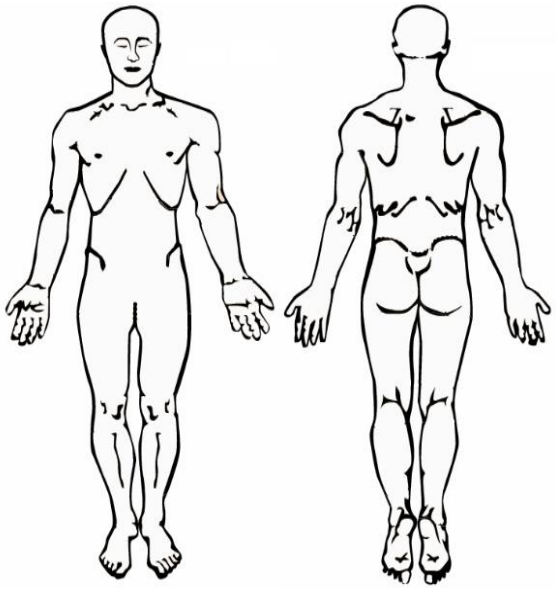
What is your main complaint? _____

_____

Rate the severity of your pain right now. Circle ONE number below.

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Please shade all complaint area(s).



Your Auto Insurance Information

Company _____

Address _____

City _____ State _____ Zip _____

Contact _____ Phone _____

Policy Holder _____

Claim Adjuster _____

Phone _____ Fax _____

Med Pay? ☐ Yes ☐ No Amount _____ Used _____

Additional Information _____

Other Vehicle's Auto Insurance Information .

Company _____

Address _____

City _____ State _____ Zip _____

Contact _____ Phone _____

Policy Holder _____

Claim Adjuster _____

Phone _____ Fax _____

Med Pay? ☐ Yes ☐ No Amount _____ Used _____

Additional Information _____

Details Regarding the Auto Accident .

Date of Accident _____ Time of Accident _____ am/pm

Were you admitted to the emergency room? ☐ Yes ☐ No

Hospital Name _____

Were you knocked unconscious? ☐ Yes ☐ No

Have you been treated by another doctor for this accident?

☐ Yes ☐ No

Explain _____

Did your body strike anything in the vehicle? ☐ Yes ☐ No ☐ Unsure

Explain _____

Did the air bag deploy and strike you? ☐ Yes ☐ No

During the impact were you facing? ☐ Right ☐ Left ☐ Forward ☐ Backward

Has this accident restricted your work performance? ☐ Yes ☐ No

Explain _____

Were there other passengers in the car? ☐ Yes ☐ No ☐ How many?

Was the police notified? ☐ Yes ☐ No

*If yes, please provide a copy of the accidental report.

Who was at fault? _____

Was there a traffic violation issued? ☐ Yes ☐ No

On what side was the impact to YOUR car?

☐ Front ☐ Back ☐ T-Bone ☐ Driver Side ☐ Passenger Side

Where were you located in the vehicle? _____

Did the vehicle ☐ Flip ☐ Spin ☐ Other _____

Have you retained an attorney? ☐ Yes ☐ No

Firm Name _____

Attorney Name _____ Contact _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Additional Accident Information .

Please give a detailed description of how this accident occurred.

_____

_____

_____

_____

Health Questionnaire

Do you have a personal physician? ☐ Yes ☐ No

Physician Name _____

Are you currently under the care of a physician_____

Explain _____

_____

Have you ever been treated by a chiropractor? ☐ Yes ☐ No

Chiropractor's Name _____

Explain _____

_____

When was the last date of your last:

Physical Exam _____ MRI_____

Spinal X-Ray _____ CT scan _____

Bone Scan _____ Other_____

For Woman:

Are you taking birth control? ☐ Yes ☐ No

Are you currently nursing? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Have you experienced any of the following conditions?

Please check all that apply

☐ Cancer	☐ Glaucoma	☐ Leukemia	☐ Rheumatism
☐ Abnormal Bleeding	☐ Chemotherapy	☐ Gout	☐ Liver Disease/ Problems	☐ Scarlet Fever
☐ Alcoholism	☐ Chicken Pox	☐ Hay Fever	☐ Low Blood Pressure	☐ Sciatica
☐ Allergies	☐ Colitis	☐ Headaches	☐ Lupus	☐ Scoliosis
☐ Alzheimer's	☐ Congenital Heart Defect	☐ Head Injury	☐ Migraine	☐ Seizures
☐ Anemia	☐ Depression	☐ Heart Disease/ Problem	☐ Mitral Valve Replacement	☐ Shingles
☐ Arthritis	☐ Difficulty Breathing	☐ Hemophilia	☐ Obesity	☐ Sickle Cell Disease
☐ Artificial Bones/ Joints	☐ Drug Abuse	☐ Hepatitis	☐ Pacemaker	☐ Sinus Problems
☐ Artificial Valves	☐ Epilepsy	☐ Herpes	☐ Persistent Cough	☐ Sleep Disorder
☐ Asthma	☐ Emphysema	☐ High Blood Pressure	☐ Psychiatric Problems	☐ Stroke
☐ Blood Clots	☐ Fainting Spells	☐ HIV/ AIDS	☐ Radiation Treatment	☐ Thyroid Problems
☐ Blood Transfusion	☐ Fatigue	☐ Kidney Problems	☐ Rheumatic Fever	☐ Other:

_____

Additional Health Information?

Please list any prescription or over the counter drugs you are currently taking.	Please list any vitamins or herbs you are currently taking.	Please list an allergies and any medications you have reactions to.
_____	_____	_____
_____	_____	_____
_____	_____	_____

Authorization and Medical Release

I affirm that the information I have given is correct to the best of my knowledge. The information I have provided will remain confidential, and I understand that it is my responsibility to inform this office of any changes in my medical status.

I understand that the health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making my collections from the insurance company. Any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me, and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize Atlas Wellness Center to furnish all the information required by the insurance company concerning my injury or illness. I hereby authorize the doctor to treat my condition as he deems appropriate and to grant full disclosure for all previous or concurrent care. In addition, I agree to grant full indemnity to the Atlas Wellness Center, and it's physicians for complications related to all pre-existing conditions medically diagnosed or disclosed.

Patient or Guardian Signature _____Date_____

Print Guardian Name _____ Relationship to Patient _____