

## Confidential Patient Information

Name \_\_\_\_\_ Hm. Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Marital Status (Circle one) M S D W Age \_\_\_\_\_  
Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Work Address \_\_\_\_\_ City, St, Zip \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ # of Children \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_  
Have you ever had Chiropractic before? Yes  No  Date \_\_\_\_\_

Is this injury or illness related to: Employment  Auto Accident   
Date: \_\_\_\_\_ Location: \_\_\_\_\_  
Workers Compensation Insurance Co.: \_\_\_\_\_ Phone: \_\_\_\_\_  
Your Auto Insurance Co.: \_\_\_\_\_ Phone: \_\_\_\_\_  
Third Party Auto Insurance Co.: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have Health Insurance? Yes  No  Subscribers Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Primary Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

All charges are due when services are rendered....

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

### RELIEF CARE

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

### CORRECTIVE CARE

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

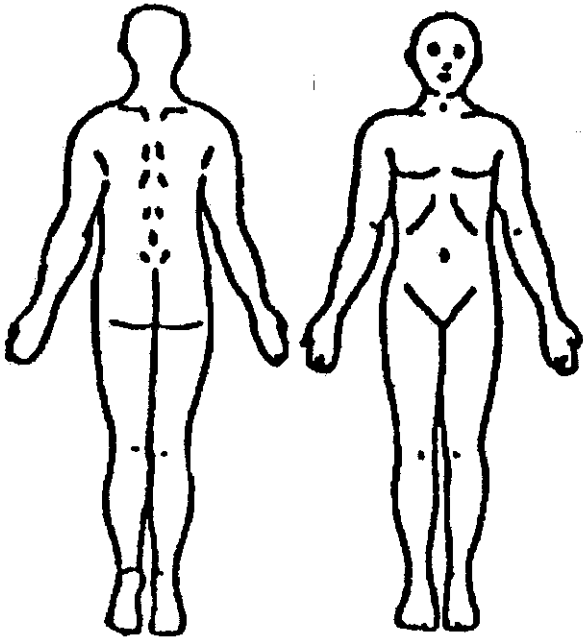
I authorize Atlas Chiropractic Center to render necessary services to me and I am responsible for all charges incurred.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or spouse's authorizing care \_\_\_\_\_

# THANK YOU FOR ALLOWING US TO SERVE YOU!

PLEASE MARK AN X ON THE DIAGRAM  
WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

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List your chief complaints in order of severity

1. 

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2. 

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3. 

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List other Chiropractic or Medical Doctors you  
have consulted for these conditions.

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Check any of the following you have had in the last  
six months:

- |  |  |
|--|--|
| <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Numbness                      |
| <input type="checkbox"/> Sinus Congestion / Allergies  | <input type="checkbox"/> Frequent Nausea / Vomiting    |
| <input type="checkbox"/> Vision Problems               | <input type="checkbox"/> Abdominal Cramps              |
| <input type="checkbox"/> Ear Aches                     | <input type="checkbox"/> Constipation                  |
| <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> Diarrhea                      |
| <input type="checkbox"/> Heart Problems                | <input type="checkbox"/> Poor / Excessive Appetite     |
| <input type="checkbox"/> Lung Problems / Congestion    | <input type="checkbox"/> Excessive Thirst              |
| <input type="checkbox"/> Blood Pressure Problems       | <input type="checkbox"/> Painful / Excessive Urination |
| <input type="checkbox"/> Ankle Swelling                | <input type="checkbox"/> Discolored Urine              |
| <input type="checkbox"/> Prostate / Sexual Dysfunction | <input type="checkbox"/> Diabetes                      |
| <input type="checkbox"/> Menstrual Cycle Dysfunction   | <input type="checkbox"/> Cancer                        |

Are you pregnant?       Yes                       No                       Not Sure