Atlanta HEALTH CONNECTION CHIROPRACTIC

PATIENT APPLICATION **Date:**_____

Last_____First_____MI____

Address_____

City_____State_____Zip_____

Cell_____

Email_____

DOB____/____/_____ Sex M F

Marital Status Single Married Divorced Widowed

Employer_____

Work Phone_____

Occupation:_____

Emergency Contact:_____

Relationship_____

Who may we thank for referring you?_____

PATIENT CONDITION

(1) Do you have Headaches Y N Migraines Y N

If so, how often?_____

(2) Reason for visit?_____

_____

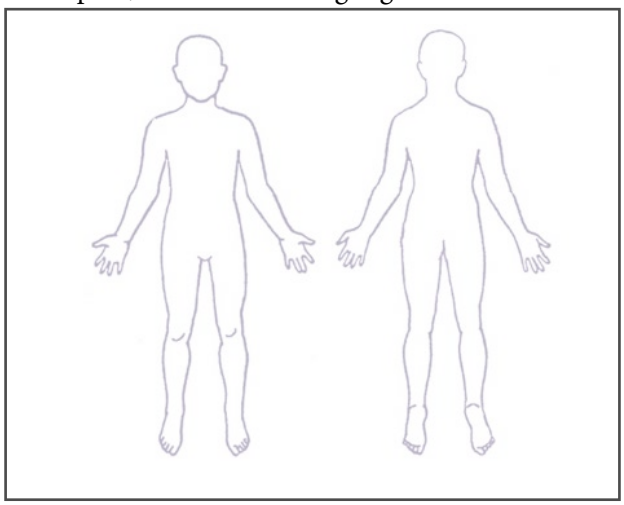
_____

(3) When did your symptoms appear?_____

_____

(4) Are these symptoms getting progressively worse? Y N

Mark and X on the picture where you continue to have pain, numbness or tingling.



Front Back

(5) Rate your pain on a scale from 1 (least) to 10 (severe)
1 2 3 4 5 6 7 8 9 10

Type of pain? Sharp Dull Throbbing Numbness Aching
Burning Tingling Cramping Stiffness Swelling

(6) How often is this pain?_____

(7) Is it CONSTANT or COMES AND GOES?

(8) Does it interfere with your: Work Sleep Recreation
Daily Routine

(9) Activities that are painful to perform: Sitting Standing Walking Bending Lying Down

(10) What have you done to try and correct your health concern?_____

_____

_____

ACCIDENT INFORMATION

(11)Are any of your conditions due to an accident? Y N

(12) Type of accident?
Auto Work Home Other (Please explain)
_____

_____

_____

(13) Attorney's Name? (If Applicable)_____

(14) Attorney's Phone # _____

(15) Please circle if you have or have had any of the following

AIDS/HIV	Alcoholism	Allergy Shots
Anemia	Anorexia	Appendicitis
Arthritis	Asthma	Bleeding Disorder
Breast Lump	Bronchitis	Bulimia
Cancer	Cataracts	Chemical Depend.
Chicken Pox	Diabetes	Emphysema
Epilepsy	Fractures	Glaucoma
Goiter	Gout	Hepatitis
Hernia	Herniated Disk	Herpes
High Bl Pressure	High Cholesterol	Kidney Stone
Liver Disease	Measles	Migraines
Miscarriage	Mono	Multiple Sclerosis
Mumps	Osteoporosis	Pacemaker
Parkinsons	Pinched Nerve	Pneumonia
Polio	Prostate Exam	Prosthesis
Psychiatric Care	Rheumatoid Arth	Rheumatoid Fever
STD	Stroke	Suicidal Thoughts
Thyroid Problem	Tonsillitis	Tuberculosis
Tumors	Typhoid Fever	Ulcer
Vaginal Infection		

(16) What treatment have you already received for your condition? Medication Surgery Physical Therapy Chiropractic None Other _____

(17)Name of the doctor(s) who have treated your condition?
_____

(18) Date of last: Physical Exam_____Spinal Xray____
Blood Test_____Spinal Exam_____
Chest X-Ray_____ Dental X-Ray_____ MIR,CT-Scan,
Bone Scan _____

(19) Exercise Habits:
None Moderate Daily Heavy

(20) Work Activity:
Sitting Standing Light Heavy

(21) Other Habits:
Smoking Pack/Day_____
Drinking Drinks/Week_____
Caffeine Cups/Day_____

(22) Are you pregnant? N Y

(23) Injuries/Surgeries you have had. Describe each.
Fall_____
Head Injury_____
Surgery_____
Broken Bones_____
Dislocations_____

(24) Medications you currently take_____
_____
_____

(25) Allergies:_____
_____

(26) Vitamins/Herb Supplements:_____
_____
_____

PATIENT SIGNATURE:_____ DATE:_____