



ATKINSON FAMILY CHIROPRACTIC, P.C.

BRYAN C. ATKINSON, D.C.

2830 E. Brown Rd. Suite A-2 Mesa, AZ 85213 (480) 324-1000

safe and natural treatment of neck and back pain, joint pain, headaches, compression trauma, and sleep disturbances

APPLICATION FOR EXAMINATION/TREATMENT

I. Patient Care

Please check the type of care desired; Relief Care ____, Corrective Care ____ or

Dr. Recommended Level of Care ____

Referred To Our Office By? : _____

II. Patient Information (Please write legibly for us)

A. Personal

Name: Mr./Ms. _____ DOB: __/__/__

(first) (middle) (last)

Social Security Number: _____ - _____ - _____

Home Address: _____ City: _____ State: _____ ZIP: _____

Home Phone. (____) _____ - _____ Cell Phone: (____) _____ - _____

E-MAIL Address: _____ @ _____

Best method to contact you (circle one) Phone- Hm. Cell; Txt.; E-mail; Other _____

Marital Status: MARRIED, SINGLE, DIVORCED or SEPARATED?

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES?

____ (____), _____ (____), _____ (____),

____ (____), _____ (____), _____ (____).

B. EMPLOYMENT

Company Name: _____ Occupation (describe): _____

Address: _____ City: _____ State: _____ ZIP: _____

Ph.: (____) _____ - _____ Ext. _____ Full time/ Part time

C. INSURANCE

Health Insurance Co. (Name): _____

Phone: (____) _____ - _____ Policy #: _____

Employee #: _____ Group #: _____

III. SPOUSE INFORMATION

Name of Spouse: _____ DOB: __/__/__

Social Security Number: _____ - _____ - _____ Cell Phone/Pager: (____) _____ - _____

Is home address and Phone same as above? YES / NO _____

Company Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ ZIP: _____

Ph.: (____) _____ - _____ Ext. _____ Full time/ Part time

Health Insurance Co. (Name): _____

Phone: (____) _____ - _____ Policy #: _____

Employee #: _____ Group #: _____

IV. EMERGENCY NOTIFICATION

Patient Name: _____

Your closest friend or relative to contact in case of an emergency

Name: _____ Relationship: _____
(first) (middle) (last)

HOME ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ Hm. Ph. (____)____-____ Cell Ph. # (____) _____-_____

Place of Employment: _____ Bus. Ph.: (____)____-_____

V. FINANCE

The patient is responsible for all fees incurred at this office and fees are payable at time of consultation, examination, laboratory, diagnostic imaging (X-ray), and treatment or when other services are performed. Exceptions must be made in advance. X-ray films remain the property of your medical file and need to remain at this clinic. Films will be made available for loan to other healthcare facilities or copies will be made available upon request and advance payment of the copy fee.

Who Will Assist You In Paying For Your Care?

Self ___ Spouse ___ Employer ___ Insurance ___ Other _____

How Will Payment Be Made? Cash ___ Check ___ Health Ins. ___ Auto Ins. ___

Credit Card (transaction fees may apply) ___ Other: _____

PATIENT'S SIGNATURE: _____ DATE: ____/____/____
(Self/Legal Guardian)

VI. AUTHORIZATIONS

I Authorize Communications Between _____ Insurance Company and/or Attorney's Office And Atkinson Family Chiropractic, PC. I Also Authorize Said Insurance Company and/or Attorney's Office To Make Benefit Payments Directly To Atkinson Family Chiropractic, PC For Services Relating To My Medical Claim/File.

I Understand, As With Any Medical Examination Or Procedure, There Are Inherent Risks To Examination And Care With Chiropractic Medicine. The Doctor Has Explained These Risks To My Satisfaction. With This Understanding, I Accept These Risks. Initials: _____

Claims Past 90 Days Due Will Be Charged 1.5% Or \$5 Per Month Late Fee, Which Ever Is Greater. Claims Past 120 Days Due Will Be Sent To Collections. The Patient/Responsible Party Will Incur All Fees And Expenses Associated With This Process.

PATIENT'S SIGNATURE: _____ DATE: ____/____/____
(Self/Legal Guardian)

Information Taken By: _____
(Office Staff)



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Providing Quality Service For Over 15 Years!

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S NOTICE OF PRIVACY RIGHTS

I hereby acknowledge receipt or notification that I have electronic access of this office's Patient's Notice of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Affirmed,

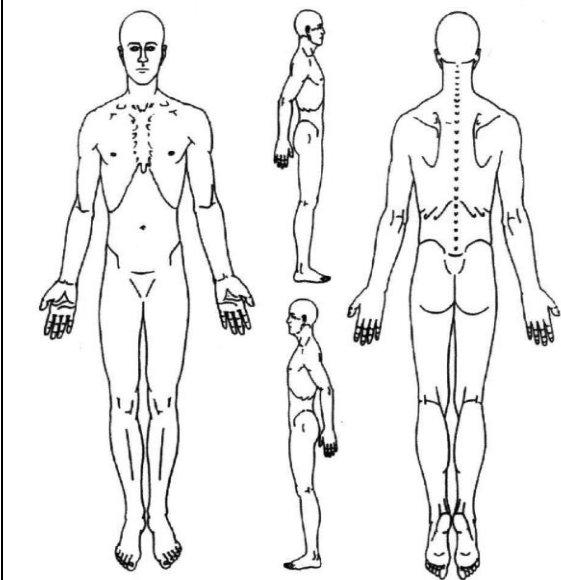
Patient Name (or legal guardian)

Date

Patient Name: _____

Please list your symptoms below and the relative pain intensity (0 – 10) for each symptom. (Example: Low back pain – 4)

Body Part	No Pain	Mild	Moderate	Severe	Unbearable						
1) _____	0	1	2	3	4	5	6	7	8	9	10
2) _____	0	1	2	3	4	5	6	7	8	9	10
3) _____	0	1	2	3	4	5	6	7	8	9	10
4) _____	0	1	2	3	4	5	6	7	8	9	10
5) _____	0	1	2	3	4	5	6	7	8	9	10
6) _____	0	1	2	3	4	5	6	7	8	9	10
7) _____	0	1	2	3	4	5	6	7	8	9	10
8) _____	0	1	2	3	4	5	6	7	8	9	10



Please mark on the diagram to the right with the following symbols as they relate to your symptoms location and description:

SS = spasms ST = stiffness DP = dull pain SP = sharp pain
 SH = shooting pain TI = tingling NU = numbness O = Other

How did this condition develop? What caused it? How did it start? _____

When were you first aware of the problem? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Over all, has this been getting ___worse? ___better? ___staying the same?

How has this affected your life?

Home: _____

Occupation: _____

Recreation: _____

Rest and Sleep: _____

Have you ever received treatment for this condition before? ___Yes ___No

If yes, When, Where, and What were your results? _____

Doctors you have consulted with in the past for this problem:

Name: _____ Ph. (____) _____

Name: _____ Ph. (____) _____

Do you have a family Dr.? Name: _____

Contact information: Ph. (____) _____ Address: _____

Patient Name: _____

Have you ever been involved in a motor vehicle accident? Y N When? 1 _____ 2 _____ 3 _____

Hit from: Front/Back Right side/Left side? Any injuries? _____

Do you know what may have caused your problem? Accidents, falls, etc.: _____

Have you had any surgeries? _____

Are you currently taking medication? Heart, Birth Control, Diabetes, Pain....?

- Name of Rx: _____ For condition: _____
- Name of Rx: _____ For condition: _____
- Name of Rx: _____ For condition: _____
- Name of Rx: _____ For condition: _____

Check any of the following symptoms you currently have or have experienced in the past 2 weeks:

- | | | |
|--|---|---|
| <input type="checkbox"/> Pregnancy-due date: _____ | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Head Seems Heavy | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Spasms | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Foot Arch Pain |
| <input type="checkbox"/> Decreased Range of Motion | <input type="checkbox"/> Feet Hot/Cold | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hands Hot/Cold | <input type="checkbox"/> Teeth Grinding |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Pins/Needles in Hands/Arms | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Radiating Pain | <input type="checkbox"/> Pins/Needles in Feet/Legs | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Numbness in Hands | <input type="checkbox"/> Arm or Hand Pain |
| <input type="checkbox"/> TMJ dysfunction | <input type="checkbox"/> Numbness in Feet | <input type="checkbox"/> Leg or Foot Pain |
| <input type="checkbox"/> Hearing Changes | <input type="checkbox"/> Chest Pain /or Pace Maker | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Back Stiffness |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> No Symptoms at all |

Symptoms other than listed above? _____

Is your pain constant? Yes No, Where? _____

Is your pain intermittent? Yes No, Where? _____

Is your pain sharp? Yes No, Where? _____

Is your pain dull? Yes No, Where? _____

Other description? _____

What is your most comfortable position (D=Day, N=Night)? Sitting Standing
 On Back On Stomach On Right Side On Left Side Other: _____

- | | |
|---|---|
| Difficult to move around in bed? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | Knee Problems? <input type="checkbox"/> Yes/ <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Difficult to Stretch or Twist? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | Cramps? <input type="checkbox"/> Yes/ <input type="checkbox"/> N Where? _____ |
| Do you feel better moving around? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | Any Recent Change In <input type="checkbox"/> Bowels? <input type="checkbox"/> Bladder? |
| Do you feel better Resting? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | and/or <input type="checkbox"/> Reproductive System(s)? None |
| Have you tried a brace? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | Are you able to take care of your own personal |
| Heel height change your pain? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | needs? Eating, Bathing, Dressing: <input type="checkbox"/> Yes/ <input type="checkbox"/> No |

Patient's Signature: _____ Date: _____ Phys: _____

