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, scoliosis, and compression trauma

APPLICATION FOR EXAMINATION/TREATMENT
Of A Minor

I. Patient Care
Please check the type of care desired; Relief Care ___, Corrective Care ___ or
Dr. Recommended Level of Care ___
REFERRED HERE BY?: _____

II. Patient Information
A. Personal
NAME: Mr./Ms. _____ DOB: ___/___/___
(first) (middle) (last)
SOCIAL SECURITY NUMBER: _____-_____-_____
HOME ADDRESS: _____ CITY:_____ STATE: ____
ZIP: _____-_____ HOME PH. (_____) _____-_____
E-MAIL ADDRESS_____@_____
Mothers name:_____ Fathers name:_____
MARITAL STATUS OF PARENTS: MARRIED, SINGLE, DIVORCED or SEPARATED?
Who has legal custody of the child? Mother, Father, Shared, Other:_____
IF THE CHILD HAS SIBLINGS PLEASE LIST THEIR NAMES AND AGES?
_____(__), _____(__), _____(__),
_____(__), _____(__), _____(__).

B. EMPLOYMENT OF PRIMARY PARENT Mother/Father
NAME: Mr./Ms. _____ DOB: ___/___/___
(first) (middle) (last)
Company Name: _____ Occupation (describe):_____
Address:_____ City:_____ State: _____ ZIP:_____
Ph.: (___)_____ Ext. _____ Full time/ Part time

C. INSURANCE
Health Insurance Co. (Name): _____ Phone:_____
Policy #: _____Employee #: _____

III. SPOUSE
Name of Spouse:_____DOB: ___/___/___
SOCIAL SECURITY NUMBER: _____-_____-_____
HOME ADDRESS: _____ CITY:_____ STATE: ___
ZIP: _____-_____ HOME PH. (_____) _____-_____
Cell Phone/Pager: (_____)_____
Company Name: _____ Occupation: _____
Address:_____ City:_____ State: _____ ZIP:_____
Ph.: (___)_____ Ext. _____ Full time/ Part time
Health Insurance Co. (Name): _____ Phone:(___)_____-_____
Policy #: _____ Employee #: _____

Patient Name: _____

IV. EMERGENCY NOTIFICATION

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

Fees Are Payable At Time Of Consultation, Examination, Laboratory, Diagnostic Imaging (X-RAY), 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. ___
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 And Options 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)

Patient Name:_____

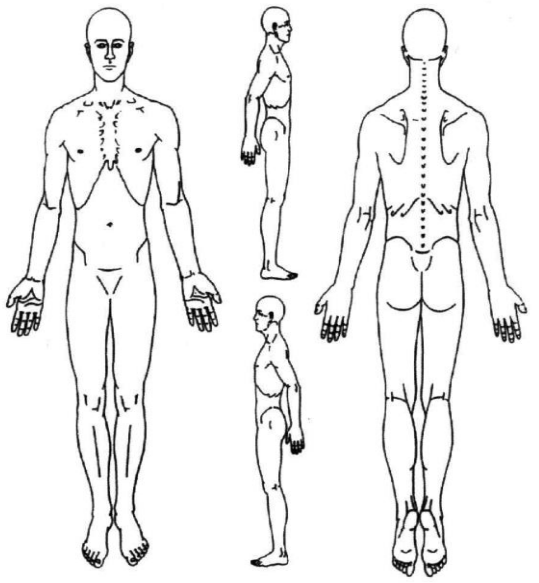
Please list your symptoms below and the relative pain intensity (0 – 10) <u>for each</u> symptom. (*Example: Low back pain – 4*)

	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:

___Pregnancy	___Low Back Pain	___Tension
___Headache	___Head Seems Heavy	___Fever
___Spasms	___Stiff Neck	___Cold Sweats
___Decreased Range of Motion	___Feet Hot/Cold	___Snoring
___Dizziness	___Hands Hot/Cold	___Teeth Grinding
___Visual Disturbances	___Pins/Needles in Hands/Arms	___Sleep Apnea
___Radiating Pain	___Pins/Needles in Feet/Legs	___Sleep Disturbances
___Anxiety/Depression	___Numbness in Hands	___ Arm or Hand Pain
___TMJ dysfunction	___Numbness in Feet	___ Leg or Foot Pain
___Hearing Changes	___Chest Pain /or Pace Maker	___ Shoulder Pain
___Loss of Balance	___Upset Stomach	___ Hip Pain
___Neck Pain	___Constipation/Diarrhea	___Back Stiffness
___Mid Back Pain	___Fatigue	___ 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? __Yes/__No
Difficult to Stretch or Twist? __Yes/__No
Do you feel better moving around? __Yes/__No
Do you feel better Resting? __Yes/__No
Have you tried a brace? __Yes/__No
Heel height change your pain? __Yes/__No

Knee Problems? __Yes/__No __Right __Left
Cramps? __Yes/__N Where? _____
Any Recent Change In __Bowels? __Bladder?
and/or __Reproductive System(s)? None
Are you able to take care of your own personal needs? Eating, Bathing, Dressing: __Yes/__No

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

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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 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.
This document can be reviewed online at www.afcmesa.com, under the "New Patient Center" tab, "Online Forms" page.

Affirmed,

_____
Patient Name (or legal guardian)

_____
Date