ATLAS SPINAL CARE

Personal & Family Information

Name _____ Referred by _____
Address _____ City _____ State ____ Zip _____
Phone: home _____ work _____ cell _____
Date of Birth _____ Age ____ Gender ☐ M ☐ F Email _____
SSN _____ Marital Status ☐ S ☐ M ☐ D ☐ W ☐ Significant Other
Occupation _____ Employer _____
Spouse's/Significant Other's Name _____
Spouse's/Sig. Other's Occupation _____ Employer _____

Names & Ages of Children
1st _____ Age ___ 4th _____ Age ___
2nd _____ Age ___ 5th _____ Age ___
3rd _____ Age ___ 6th _____ Age ___

Have you ever been to a Chiropractor before? ☐ Y ☐ N Results _____
Have you ever been to a NUCCA Doctor before? ☐ Y ☐ N Results _____

You deserve to be healthy and have a good Quality of Life. Life is a miracle and so are you. When you were created you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause distortion to your health expression, called the Atlas Subluxation. Removing this interference restores your natural health expression and a Quality of Life that you deserve. The information you provide is crucial in order to determine if you have the Atlas Subluxation interference.

Personal Health History

<u>Birth Process</u> (Yours)
☐ Long/Difficult Delivery ☐ Forceps ☐ Caesarian ☐ Breach ☐ Induced Labor
☐ Home Birth

<u>Growth & Development</u>
☐ Head Injuries ☐ Spine Injuries ☐ Child Abuse ☐ Falls ☐ Ever Unconscious
☐ Broken Bones ☐ Vaccines Other _____

<u>Current Lifestyle & Habits</u>
☐ Smoke Amount _____ ☐ Alcohol Amount _____
☐ Exercise Frequency/Type _____ ☐ Never Exercise
☐ Recreational Drugs ☐ Artificial Sweeteners ☐ Yearly Flu Shots ☐ Poor Diet
☐ High Stress ☐ From Family ☐ From Work ☐ No Stress
☐ Other _____

Current Health Condition

Please list your **current conditions** below in order of priority. Then describe each one.

1. _____ Is it constant or does it come and go? _____
Describe how it feels? _____
How long have you had this symptom? (write in) _____Weeks _____Months _____Years
What activities aggravate your condition? _____
Is it worse at different times of the day? ☐ AM ☐ PM ☐ Sleeping ☐ No
It is interfering with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Is the condition progressively getting worse? ☐ Yes ☐ No ☐ Staying the Same

2. _____ Is it constant or does it come and go? _____
Describe how it feels? _____
How long have you had this symptom? (write in) _____Weeks _____Months _____Years
What activities aggravate your condition? _____
Is it worse at different times of the day? ☐ AM ☐ PM ☐ Sleeping ☐ No
It is interfering with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Is the condition progressively getting worse? ☐ Yes ☐ No ☐ Staying the Same

3. _____ Is it constant or does it come and go? _____
Describe how it feels? _____
How long have you had this symptom? (write in) _____Weeks _____Months _____Years
What activities aggravate your condition? _____
Is it worse at different times of the day? ☐ AM ☐ PM ☐ Sleeping ☐ No
It is interfering with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Is the condition progressively getting worse? ☐ Yes ☐ No ☐ Staying the Same

4. _____ Is it constant or does it come and go? _____
Describe how it feels? _____
How long have you had this symptom? (write in) _____Weeks _____Months _____Years
What activities aggravate your condition? _____
Is it worse at different times of the day? ☐ AM ☐ PM ☐ Sleeping ☐ No
It is interfering with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Is the condition progressively getting worse? ☐ Yes ☐ No ☐ Staying the Same

Other Doctors seen for these conditions _____
_____

Have you ever had any falls, accidents or sports injuries? ☐ Yes ☐ No
Please explain _____
_____

How many automobile accidents have you been in (even minor)? Write year in the blank
_____ Rear End _____ Head On _____ Broadside _____ Rolled _____ Thrown Out

Check other symptoms you have experienced in the past 6 months

☐ Acid Reflux	☐ Diarrhea	☐ Headaches	☐ Neck Stiff
☐ Allergies	☐ Dizziness	☐ High/Low Blood Pressure	☐ Numbness
☐ Balance	☐ Ear Ringing	☐ Irritability	☐ Panic Attack
☐ Bowel Problem	☐ Fainting	☐ Knee Pain	☐ Pins & Needles
☐ Carpal Tunnel	☐ Fatigue	☐ Light Bothers Eyes	☐ Shortness of Breath
☐ Chest Pain	☐ Fevers	☐ Loss of Memory	☐ Shoulder Tension
☐ Cold Sweats	☐ Foot Pain	☐ Low Back Pain	☐ Sinus Problems
☐ Constipation	☐ Gas	☐ Menstrual Pain	☐ Sleeping Problems
☐ Depression	☐ Hand Pain	☐ Neck Pain	☐ Stomach Upset

Other Symptoms _____

Pregnant? ☐ Yes ☐ No

Explain any surgeries in the past year _____
_____

List your medications and what they are for _____
_____

If you could get rid of one symptom, what would that symptom be? _____
Explain why_____

If you could get rid of this symptom, what would your commitment be from 1 to 10 (10 the highest commitment, 1 the lowest) Circle 1 2 3 4 5 6 7 8 9 10

As a result of my NUCCA Spinal Care in this office, I would like to achieve: (Please check all that apply)

☐ Symptom Relief ☐ More Energy ☐ Become More Active ☐ Healthier Spine

☐ Healthier Body ☐ Healthier Lifestyle ☐ Better Quality of Life

What type of care do you want?

☐ Relief Care that is necessary to reduce or eliminate my symptoms or pain, but not the cause of it. This care is not typically recommended because the health problem is never handled and usually gets worse over time.

☐ Corrective Care to correct the problem by addressing the cause of why my body may not be healing, adapting or repairing and Stabilization Care for long lasting results. Corrective and Stabilization Care varies in length of time, but is more lasting, improves your overall health, and its goals are to enhance your Quality of Life.

☐ Wellness Care to maintain my health and Quality of Life and to prevent my body from losing its ability to heal, adapt and repair. I may or may not have symptoms.

☐ Not sure what type of care I want.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and should I desire credit to be extended, I authorize any necessary credit verification. I also understand that if I suspend or terminate my care, fees for professional services rendered will be immediately due and payable. I have been advised and concur, past due accounts will bear interest at 1% per month on the past due balance. I am responsible for costs required to enforce collection of my account including, but not limited to, collection fees, attorney fees and court costs. There is a $35.00 charge for returned checks.

_____ _____

Signature of Patient or Guardian Date

DO NOT WRITE BELOW THIS LINE

X-Rays ☐ Yes ☐ No ☐ Consultation Only

Current Health Care Providers

With your permission we would like to communicate about your care with your other providers.

Primary Physician

Office Name: _____

Physician Name: _____

Address: _____

Phone Number: _____

Dentist

Office Name: _____

Physician Name: _____

Address: _____

Phone Number: _____

Chiropractor

Office Name: _____

Physician Name: _____

Address: _____

Phone Number: _____

Other Provider

Office Name: _____

Physician Name: _____

Address: _____

Phone Number: _____

Other Provider

Office Name: _____

Physician Name: _____

Address: _____

Phone Number: _____

Health Survey

(SF-12 v2 Standard US Version 2.0)

NAME _____ DATE _____ CASE # _____

TO BE COMPLETED BY PATIENT

Directions: This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. If you need to change an answer, completely erase the incorrect mark and fill in the correct circle. If you are unsure about how to answer a question, please give the best answer you can.

Mark only 1 answer for each question. Make a check mark in the appropriate box.

	Excellent	Very Good	Good	Fair	Poor
01. In general, would you say your health is:	☐	☐	☐	☐	☐
The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?	Yes, limited a lot	Yes, limited a little	No, not limited at all		
02. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐		
03. Climbing several flights of stairs	☐	☐	☐		
During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
04. Accomplished less than you would like	☐	☐	☐	☐	☐
05. Were limited in the kind of work or other activities	☐	☐	☐	☐	☐
During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
06. Accomplished less than you would like	☐	☐	☐	☐	☐
07. Did work or activities less carefully than usual	☐	☐	☐	☐	☐
08. During the <u>past 4 weeks</u>, how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)?	Not at all	A little bit	Moderately	Quite a bit	Extremely
	☐	☐	☐	☐	☐
These questions are about how you feel and how things have been with you during the <u>past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks</u>…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
09. Have you felt calm and peaceful	☐	☐	☐	☐	☐
10. Did you have a lot of energy	☐	☐	☐	☐	☐
11. Have you felt downhearted and depressed	☐	☐	☐	☐	☐
12. During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, etc.)?	☐	☐	☐	☐	☐

Informed Consent For Upper Cervical Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care in general include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic adjustments and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in early stages of a stroke. In essence, there may be a stroke already in process. There have been no reports of any such injuries occurring in association with the gentle upper cervical correction that we perform in this office.

Prior to receiving care in this office, a health history and examination will be completed. These procedures are performed to assess your specific condition, your overall health, and, in particular, your spinal health. These procedures will assist us in determining if upper cervical care is needed or if any further examinations or studies are needed before initiating care, and all relevant findings will be reported to you prior to care.

We do not offer to diagnose or provide care for any disease or condition other than your Atlas Subluxation. However, if during the course of evaluation and care we encounter non-chiropractic or unusual findings, we will inform you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY GOAL IS TO ALLOW THE BODY TO DO ITS JOB.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the upper cervical chiropractic care including upper cervical spinal corrections, as reported following my assessment.

_____ _____

Patient Name (PRINTED) Relationship to Patient

_____ _____

Patient or Legal Guardian Signature DATE

_____ _____

Witness Signature (Office Staff) DATE