ATLAS FAMILY CHIROPRACTIC

DR. TYSON E. SHARDLOW

Dr. Shardlow and Atlas Family Chiropractic are sincerely committed to working with you to achieve your healthcare goals. The information below will help us in better understanding your overall health status so that we may provide you with the highest possible quality of individual care. Please take a few minutes to complete this form as accurately and as completely as possible.

CONFIDENTIAL PATIENT DATA

PLEASE PRINT CLEARLY

Is this visit the result of an auto accident or work-related injury? ☐Yes ☐No

(If yes, you may need to fill out paperwork specific to your injury)

PATIENT INFORMATION Today's Date: _______________

Name: ____ Date of Birth: ______________

Address: ____

City/Town: ____________________________ State: __________ Zip Code: ____________

Home Phone: __________________________ Work Phone: __________________________

Cell Phone: ______________________ E-Mail: ____________________________________

Social Security #: ______________________ Age: ___________ ☐ Male ☐ Female

Occupation: _____________________________Employer: ___________________________

Marital Status ☐ Married ☐Single ☐Divorced ☐Separated ☐Other ____________

Name of Spouse: ____________________________Occupation: _______________________

Children's Names/Ages: ____

Preferred Method of Contact (choose one): ☐Email ☐Home ☐Cell ☐Work ☐USPS

Emergency Contact: ______________________________ Phone: _____________________

Referred to this office by: Online/Web ☐ Clinic Location ☐Doctor ☐Other__________

☐Family/Friend – Who may we thank for your referral?____________________________

Primary Care Physician: ____________________________Telephone: _________________

Name of Primary Care Practice:____

Address: ______________________________City/State: __________________Zip: _______

Approximate Date of Last Visit to Primary Care Physician: _________________________

Reason for Visit: ____

Have you been treated by a specialist for any condition in the last year? ☐Yes ☐No

Name of Clinician:______________________ Practice: ______________________________

Briefly Describe Condition: ____

Date of Last Physical Exam: ____

Medical/Family History (S = Self M = Mother F = Father)

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	Rheumatism	❑	❑	❑	Muscular Dystrophy
❑	❑	❑	Headaches	❑	❑	❑	Bladder Trouble	❑	❑	❑	Stroke
❑	❑	❑	Polio	❑	❑	❑	Indigestion	❑	❑	❑	Concussion
❑	❑	❑	Anemia	❑	❑	❑	Scarlet Fever	❑	❑	❑	Neck Pain
❑	❑	❑	Heart Disease	❑	❑	❑	Bone Fracture	❑	❑	❑	Tuberculosis
❑	❑	❑	Poor Circulation	❑	❑	❑	Kidney Disorder	❑	❑	❑	Diabetes
❑	❑	❑	Arthritis	❑	❑	❑	Scoliosis	❑	❑	❑	Nervousness
❑	❑	❑	Hepatitis	❑	❑	❑	Bowel Control Loss	❑	❑	❑	Venereal Disease
❑	❑	❑	Reproductive Disorders	❑	❑	❑	Menstrual Cramps	❑	❑	❑	Dislocated Joints
❑	❑	❑	Asthma	❑	❑	❑	Seizures	❑	❑	❑	Numbness
❑	❑	❑	High Blood Pressure	❑	❑	❑	Cancer	❑	❑	❑	Epilepsy
❑	❑	❑	Rheumatic Fever	❑	❑	❑	Multiple Sclerosis	❑	❑	❑	Osteoporosis
❑	❑	❑	Back Pain	❑	❑	❑	Sinus Trouble	❑	❑	❑	German Measles
❑	❑	❑	HIV/ARC	❑	❑	❑	Chest Pain	❑ Other ______________			

Female Patients: Are you currently (or possibly) pregnant?: ☐Yes ☐No

Current Medication(s):	Reason(s) For Taking:
1.____________________	____
2.____________________	____
3.____________________	____

Past Surgical History:

1.____ Date: _______________

2.____ Date: _______________

3.____ Date: _______________

So we can learn more about your lifestyle habits please answer the following:

1. Do you smoke tobacco? ☐Yes ☐No If yes, how much?________________________
2. Do you drink alcoholic beverages? ☐Yes ☐No If yes, how much?_______________
3. Do you engage in any hobbies or lifestyles that could be deemed risky? ☐Yes ☐No
   If yes, please list____
4. Are you currently following a vegan/vegetarian/raw food diet? ☐Yes ☐No
5. How often do you exercise?________________Which Activities? ________________

____

Are you only looking for short-term relief of your condition, or do you want to make positive changes to improve your overall health? _________________________________

How long has it been since you felt really good? __________________________________

____ ____________________

Signature of Patient (or Guardian, if Minor Child) — Date