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
Employer: _____ Occupation: _____
Are you a student? □Yes □No If Yes: □Full-Time □Part-Time
Marital Status □ Married □Single □Divorced □Separated □Other _____
Name of Spouse: _____ Date of Birth: _____
Spouse's Employer: _____ Occupation: _____
Children's Names/Ages: _____

Emergency Contact: _____ Phone: _____

Referred to this office by: □Yellow Pages □ Online/Web Source □ 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
If yes, describe condition: _____
Date of Last Physical Exam: _____

Have you had previous chiropractic care? ☐Yes ☐No
If yes, who was the doctor? _____ Condition: _____
Approximate date of last visit: _____ Duration of care: _____

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

SURGICAL HISTORY:
1. _____ Date: _____
2. _____ Date: _____

ACCIDENT HISTORY:
☐Work Injury ☐Auto ☐Other 1. _____ Date: _____
☐Work Injury ☐Auto ☐Other 2. _____ Date: _____
☐Work Injury ☐Auto ☐Other 3. _____ Date: _____

Current Medication(s): Reason(s) for taking:
1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Please Describe Your Present Conditions:

Region of Complaint_____ *(example: low back, neck, headache)*
Pain Level: 1 2 3 4 5 6 7 8 9 10 (*1 is least, 10 is worst*)
Frequency: Constant – Frequent – Intermittent – Occasional

Region of Complaint_____ *(example: low back, neck, headache)*
Pain Level: 1 2 3 4 5 6 7 8 9 10 (*1 is least, 10 is worst*)
Frequency: Constant – Frequent – Intermittent - Occasional

What activities of daily living cause you pain or discomfort? (ex: housework, driving, yard work, laying in bed, etc.) _____

_____

What movements or positions aggravate your condition(s)? (ex: bending, exercising, standing, sitting, etc.)_____

_____

What relieves your condition(s)? (ex: hot showers, ice packs, pain relievers, stretching, etc.)

_____

_____

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
   If yes please explain_____
5. How often do you exercise?_____Which Activities? _____

_____

Are you interested in nutritional advice or information regarding lifestyle modification?

_____

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

_____ _____

Signature of Patient
(or Guardian, if Minor Child)

Date