OWENSBORO
atlas center

FOR OFFICE USE ONLY
Date: _____
PM ID: _____

PERSONAL DATA

Name: _____ Age: _____ Date of Birth: ____ /____ /____

Both Parents' Names (if under 18): _____

Home Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____ @_____

Occupation: _____ Employer: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse/Partner: _____

# of Children: ___ Children's Name(s): _____

Whom may we thank for referring you to our office, or how did you hear about us?

_____

What do you know about us? _____

What concerns do you feel we can address for you? _____

_____

Are these concerns affecting your quality of life? (Please circle all that apply.)

Work:	☐Y	☐N	Driving:	☐Y	☐N	Sleep:	☐Y	☐N
School:	☐Y	☐N	Walking:	☐Y	☐N	Sitting:	☐Y	☐N
Exercise/sports:	☐Y	☐N	Eating:	☐Y	☐N	Love life:	☐Y	☐N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received chiropractic care? ☐ Y ☐ N Name of D.C. _____

How long under care? ☐____ days ☐____ weeks ☐____ months ☐____ years

Date of last visit: _____ Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (Check all that apply.)

☐ Medical Doctor	☐ Chiropractor	☐ Osteopath	☐ Physical Therapist
☐ Counselor	☐ Dentist	☐ Naturopath	☐ Massage Therapist
☐ Acupuncturist	☐ Psychologist	☐ Other OB/GYN	

Reason: _____

_____

FOR WOMEN

Are you pregnant? ☐Y ☐N Date of last menstrual period: _____

If pregnant, due date: _____ Name of OB/GYN or Midwife: _____

Where will you be birthing your baby? ■ Hospital ☐ Home ☐ Birthing Center ☐ Other_____

If you have recently delivered a child, how long ago? _____ Where? _____

Health, Wellness and Chiropractic Care

- The primary system in the body which coordinates health is the NERVE SYSTEM.
- The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
- Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
- VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

**Vertebral Subluxations can have Physical, Emotional, and Chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system.

Please CHECK where and how **you** were birthed. (If you do not know, please skip to next question.)

☐ Home	☐ Natural	☐ Cord around neck	☐ Caesarian section	☐ Forceps
☐ Breech	☐ Hospital	☐ Prolonged labor	☐ Drug induced labor	☐ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present. Have you had any accidents due to any of the following? (Check all that apply.)

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse

If yes, state type of injury and date:

_____

Have you ever hurt, broken, fractured, sprained, injured, or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ☐ Y ☐ N

If yes, list body parts injured and dates of injuries:

_____

Have you ever been hospitalized or had surgery? ☐ Y ☐ N

If yes, state reason and dates: _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood trauma	☐Y ☐N	Loss of loved one(s)	☐Y ☐N	Abuse	☐Y ☐N
Work or School	☐Y ☐N	Divorce/separation	☐Y ☐N	Financial	☐Y ☐N
Lifestyle change	☐Y ☐N	Parents' divorce	☐Y ☐N	Illness	☐Y ☐N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or placed on the skin (e.g. food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? □ Y □ N If yes, did you have a reaction? □ Y □ N □ Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

□ Toxic chemicals □ Secondhand smoke □ Drug therapy
□ Radiation □ Chemotherapy □ Other

If yes, please list: _____

Do you have allergies or sensitivities to any foods? □ Y □ N If yes, please list below:

_____

Do you presently consume any of the following?

□ Coffee/caffeine □ Alcohol □ Tobacco □ Over the counter drugs □ Prescribed drugs

Please list all of the medications you are currently taking (prescribed and over the counter): _____

_____

_____

How many bowel movements do you have in a day? _____

How much water do you consume per day? _____

Note: it is important that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health? □ Good □ Fair □ Poor

How do you grade your emotional/mental health? □ Good □ Fair □ Poor

How do you rate your overall "quality of life"? □ Good □ Fair □ Poor

How do you rate your overall sleep quality? # of hours/night ____ ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regimen? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply.)

☐ Relief of a symptom or problem
☐ Relief and prevention of a symptom or problem
☐ Healthier spine and nerve system
☐ Optimal health on all levels
☐ OTHER _____

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FINANCIAL INFORMATION

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ☐ Cash ☐ Check ☐ Credit Card

Day 1 (first visit) Includes: Consultation, All Comprehensive Neurological, Postural, & Structural Exams, and 3D Spinal Imaging.
Day 2 (second visit) Includes: Doctor's Report of Findings

Total Fee: $199

PLEASE READ AND SIGN

1. I acknowledge that some of the services offered by Owensboro Atlas Center may not be covered by insurance, and I am responsible for all fees incurred during office visits.
2. I have been informed that a copy of Owensboro Atlas Center's "*Notice of Privacy Practices for Protected Health Information (HIPAA)*" brochure is available for my review in the office.
3. I consent to receive communication from Owensboro Atlas Center via email, postal mail, text and telephone messaging in connection with my care.
4. I agree to follow doctor's recommendations to the absolute best of my ability to ensure that I get the absolute best results.
5. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for my payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if my child's care is suspended or terminated, any fees for professional services rendered will become immediately due and payable.

The information I have provided on this case history form is true and accurate to the best of my knowledge. I give the doctor at Owensboro Atlas Center permission to examine and render care. This initial visit includes a health history consultation, chiropractic exam and evaluation, neurological exam via infrared thermography, 3D spinal x-rays and any initial care that is determined to be clinically necessary and mutually agreed upon.

Patient Name (Printed): _____

Signature: _____ Date: _____

If minor, please include the signature of Parent or Legal Guardian below:

_____ Date: _____

Thank you for choosing Owensboro Atlas Center!

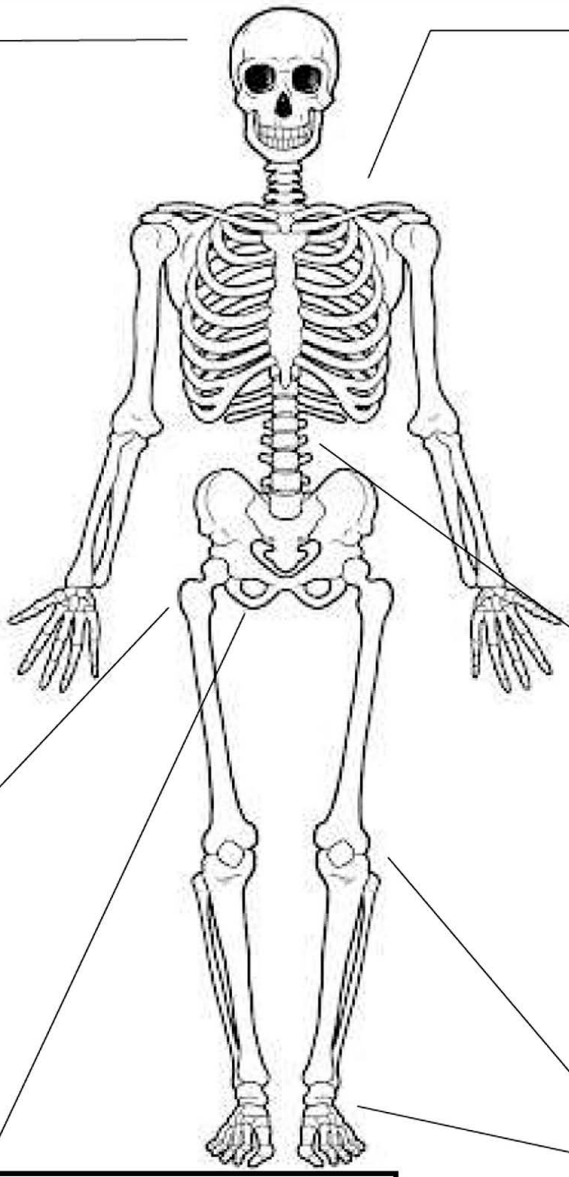
We look forward to serving you and your family!

Personal Health History

Please check **any or all** that applies to your health history **previously or currently**.

___ Allergies
___ Headaches
___ Facial pain
___ Bleeding gums
___ Vision problems
___ Hearing loss
___ Ringing in the ears
___ Ear infections
___ Sneezing
___ Loss of smell
___ Sinus issues
___ Change of taste
___ Difficulty swallowing
___ Bad breath
___ Neck pain
___ Nausea/vertigo
___ Herniated disc
___ Depression/anxiety
___ Fainting
___ Eczema/psoriasis

___ Asthma
___ Frequent colds/cough
___ Shortness of breath
___ Pneumonia
___ Chest pain
___ Rib pain
___ Shoulder pain
___ Mid back pain
___ Reflux
___ Heart palpitations
___ High blood pressure
___ Arm/hand numbness
___ Shingles
___ Frozen shoulder
___ Tender breasts



___ Hip pain
___ Sciatica
___ Leg pain/cramping
___ Arthritis/bursitis
___ Incomplete void

___ Low back pain
___ Herniated disc
___ Stomach cramping
___ Diarrhea
___ Constipation
___ Scoliosis
___ Chron's disease
___ Kidney stones
___ Gall bladder stones
___ Colitis

Male:
___ Erectile dysfunction
___ Frequent UTI
___ Testicular pain/swelling
___ Hemorrhoids
___ Prostate issues
___ Difficulty urinating
___ Decreased sex drive

Female:
___ Abnormal menses/PMS
___ Age of first mense ___
___ # of pregnancies ____
___ Birth control
___ Frequent UTI
___ Yeast infection
___ Decreased sex drive

___ Knee/foot pain
___ Arthritis
___ Joint stiffness
___ Plantar fasciitis
___ Leg/foot numbness
___ Cannot lift leg
___ Bunions
___ Fungus/nail issues

Drug Allergies: _____
Smoking History: _____
Medications: _____

Doctor's Notes: _____

_____