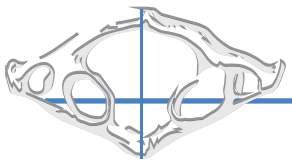


Atlas Spinal Care

Personal Health History Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

*please circle your preferred contact number

E-mail: _____

Would you like to be added to our (e)mailing list to receive occasional Healthy Tips? ☐ Yes ☐ No

Date of Birth: _____ Age: _____ Marital/Partnership Status: _____

Number of Children: _____ Name(s): _____

Social Security Number: _____-_____-_____

Emergency Contact: _____ Phone: _____

Occupation: _____ Employer: _____

Address: _____

Whom can we thank for referring you to Atlas Spinal Care? _____

Why are you seeking care in the office?

☐ To get out of pain
☐ Do not know
☐ To experience a new degree of health and healing
☐ To be more connected with my body and self
Other: _____

Have you ever been to a NUCCA Practitioner in the past? ☐ Yes ☐ No

What was your experience? _____

Have you ever been to any other type of Chiropractor in the past? ☐ Yes ☐ No

What was your experience? _____

How Can We Help?

What specific condition(s) or symptom(s) bring you into the office today? _____

_____

☐ I have no complaints. I am here for a Wellness Check-up.

This condition is a result of: ☐Motor Vehicle Accident ☐Work Injury ☐Other: _____

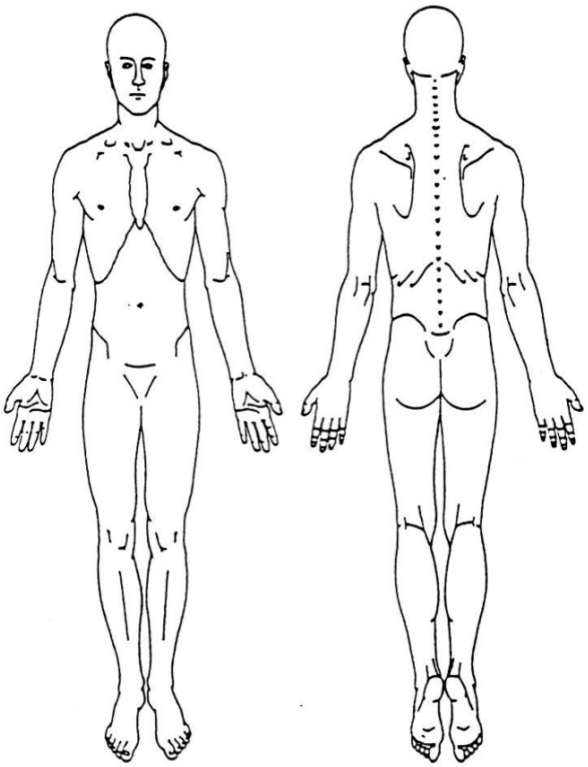
Have you done anything or sought treatment for this situation or condition? If so, what was *done* and what were you *told?*

_____ Did it seem to work? ☐ Yes ☐ No

When did you first notice your symptoms? _____

How extreme are you current symptoms? 0 ----------5----------10
Absent Uncomfortable Agonizing

Please Circle the areas on the Illustration
"o" for the current condition
"x" for conditions experienced in the past



What does it feel like?

☐Numbness	☐Tingling	☐Stiffness
☐Dull	☐Aching	☐Cramps
☐Nagging	☐Sharp	☐Burning
☐Shooting	☐Throbbing	☐Stabbing

Other: _____

How often do you feel it? ☐Constant ☐Comes & Goes
How many episodes per day/week/month? _____
How long does an episode last? _____

Does it affect other areas of your body? ☐ Yes ☐ No
What areas does the pain radiate, shoot, or travel?

_____

What makes it worse (such as time of day, movements, certain activities)?

_____

What makes it better?

_____

What else should we know about your current condition? _____

_____

In your opinion, what is the *cause* of your current condition? _____

_____

Activities of Daily Living

Is this condition currently interfering with your activities of daily living? If yes, please list the activities that are limited or have diminished as a result of this condition.

1. _____ 2. _____ 3. _____

*Examples can include but are not limited to: sitting/standing/walking for a period of time or distance, bending, driving a car, looking over shoulder, household chores, career or work, recreational activities, sleep exercise, etc.

In addition to the main reason for your visit today, what additional health goals do you have?

_____

Review of Systems & Past Personal, Family, Social History

Please check the illnesses you have currently or have in the past. (- have had + have now)

□Aids	□Alcoholism	□Allergies	□Arteriosclerosis
□Cancer	□Chicken Pox	□Diabetes	□Epilepsy
□Glaucoma	□Goiter	□Gout	□Heart Disease
□Hepatitis	□HIV Positive	□Malaria	□Measles
□Multiple Sclerosis	□Mumps	□Polio	□Rheum Fever
□Scarlet Fever	□STD's	□Stroke	□Tuberculosis
□Typhoid Fever	□Ulcer	□Other: _____	

Have you had any surgeries?

1. Type:	When?	Doctor
2. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems?)

1. Type:	When?	Hospitalized? Yes□ No □
2. Type:	When?	Hospitalized? Yes□ No □

Have you had any x-rays taken?

Area of Body:	When?	Where?

Do you wear orthotics or heel lifts? ☐ Yes ☐ No

Current Medications & Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription & non)

_____

_____

Please list any nutritional supplements, vitamins, homeopathic remedies you presently take and why:

_____

_____

Family History

Please list any Past or Present health conditions

Relative	Age	State of Health	Condition
Mother		□Good □Poor	
Father		□Good □Poor	
Sibling 1		□Good □Poor	
Sibling 2		□Good □Poor	

Are there any other hereditary health issues that you know about? _____

Stress

Because the accumulation of stress affects our health and ability to heal, please list your top three stresses (you have ever had) in each category:

Physical stress (falls, accidents, work postures, etc.)

1. _____
2. _____
3. _____

Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

1. _____
2. _____
3. _____

Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

1. _____
2. _____
3. _____

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Atlas Spinal Care and Dr. Lucas McCully to release any information, including diagnosis and the records of any treatment or examination rendered to me, or my child, during the period of such chiropractic care to third party payers and/or health practitioners.

Patient or parent Signature: _____ Date: _____