Atlas Injury to Health 424 N. Dillard St. Winter Garden – FL, 34787 (P) 407.656.0390 (F) 407.656.3395

APPLICATION FOR TREATMENT

Please check the type of care desired: □ Temporary Relief □ Lasting Correction

□ Check here if you want the Doctor to select the type of care is best for you.

Date :_____

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Home Phone Number: _____Cell Phone Number: _____

Work Phone Number: _____ E-mail Address: _____

Check if you are: □ Married □ Single □ Widowed □ Divorced □ Separated

Name of Husband or Wife: _____Ages of Children: _____

Place of Employment: _____ Spouse's Employment: _____

Your Days Off: _____ Referred to Our Office by: _____

Person Responsible for Your Bill: □ Self □ Spouse □ Employer □ Insurance □ Other

How Payment Will Be Made:

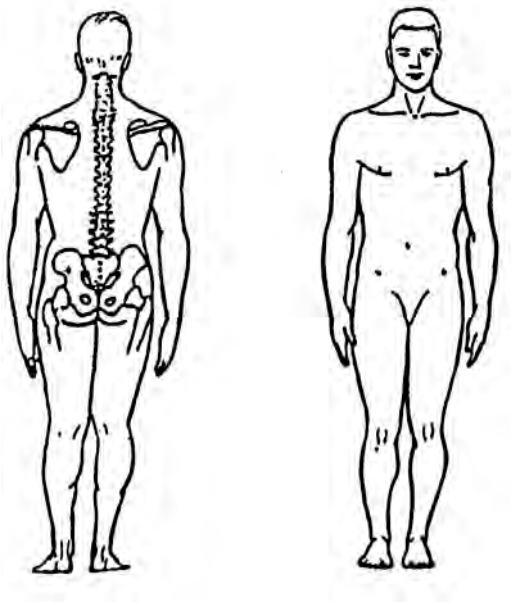
□ Cash □ Workmen's Comp □ Health Insurance

□ Check □ Credit Card □ Automobile Ins. Policy

Name of Insurance Company: _____

Insurance Company Address: _____

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example: dull, sharp, constant, off & on, when standing, when sitting, etc., etc. COMPLETE THESE DIAGRAMS



Major Complaints

Please Describe only your Major Problem

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Atlas Injury to Health 424 N. Dillard St. Winter Garden – FL, 34787 (P) 407.656.0390 (F) 407.656.3395

How did this condition develop? What caused it? How did it start? _____

_____

_____

When was the very first time you were aware of this condition? _____

Have you ever had this problem or a similar problem before? If yes, please explain. _____

_____

Have you ever received any treatment for this condition? If yes, where and when, and what were your results? _____

_____

Has this problem been getting better, worse, or staying the same? _____

_____

Is there anything you do that makes your condition worse? _____

_____

How has this condition affected your life?

A. Home Life_____
B. Occupational Life _____
C. Recreational Life _____
D. Rest/Sleep Life _____

Have you ever been in an automobile accident? If yes, when? _____

Are there any accidents, falls, etc. that might have caused your problem? _____

_____

_____

Is there any medical diagnosis of your complaint? _____

_____

Please list past surgeries of any type: _____

_____

Please check the types of medications you take as of now:

□ Nerve Pills □ Pain Killers □ Muscle Relaxers □ "Pep" Pills

□ Tranquilizers □ Insulin □ Birth Control Pills □ Other (please list)

_____

Have you consulted a chiropractor in the past? If yes, please list name, dates, and for what problem.

_____

Payment in full is expected at the time of visit. As a courtesy to you, we may file insurance; however, any outstanding balance is the patient's sole responsibility. If you fail to pay the balance in full and we are forced to file a collection suit, you will be responsible for all court and attorney fees.

Patient's Signature_____ SS#_____

Date_____

Atlas Injury to Health

MEDICAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING CONDITIONS APPLY TO YOU OR YOUR FAMILY MEDICAL HISTORY

YOU	FAM.	Condition	YOU	FAM.	Condition
		Allergies			Artificial Implants
		Arthritis			Blood Disorders
		Endocrine disorders: diabetes, osteoporosis, thyroid, etc.			Heart/Circulatory Disorders
		Eyes/Vision Disorders			HIV Disorders
		Liver Disease			Kidney/Urinary Disorder
		Lung/Respiratory Disorders			Muscle Disorders
		Nervous Disorders: multiple sclerosis, Alzheimer's, epilepsy, etc.			Stomach/Intestinal Disorders

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS: _____ CHILDREN: _____

SMOKER: YES / NO ALCOHOL CONSUMPTION: YES / NO RECREATIONAL DRUGS: YES / NO

Allergies to any medications: _____

Surgical History: _____

Occupation: _____

Have you had to reduce work related activities due to injuries sustained from this accident? YES / NO

LIST ALL OVER THE COUNTER AND PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

Prior to this occurrence, have you been in an auto accident? YES / NO WHEN? _____

DESCRIBE: _____

Have you had any other personal injury or incident? YES / NO WHEN? _____

DESCRIBE: _____

Is there any possibility that you may be pregnant?YES / NO / MAYBE

How far along? _____*Due date:* _____/_____/_____

PATIENT SIGNATURE: _____ **Date:** _____

Winter Garden
424 N. Dillard St. Winter Garden, FL 34787
Phone: 404-656-0390 Fax: 407-656-3395