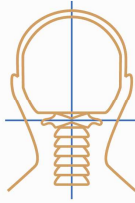


Welcome to:



Atlas Chiropractic
The Light Touch — The Right Touch

Practice Membership Information*

Thank you for choosing Atlas Chiropractic for your health and wellness needs. If you have any questions, please do not hesitate to ask. We will be happy to help.

Today's Date: _____ Sex: Male Female
Full Name: _____ SS#: _____
Address: _____ Birth date: _____
City, State, Zip: _____ Home phone: _____
Where do you prefer to receive calls? _____ Work Phone: _____
Your employer: _____ Cell Phone: _____
Occupation: _____ Work place: _____
Email address: _____

Are you: a Minor Single Married Divorced Widowed Separated

Names of Spouse and children: _____
Person to contact in case of emergency: _____ Phone: _____
Primary Care MD: _____ Phone: _____
Whom may we thank for referring you to us? _____

*** If this is a worker's compensation case or a motor vehicle accident, please stop and inform the receptionist.**

Responsible Party

Name of person responsible for this account: _____
Address: _____ Phone: _____
City, State, Zip: _____ Work Phone: _____
Relationship to patient: _____
Method of payment for today's charges: Cash, Check, Charge

Notice: All first visit charges are payable when services are rendered. The fee paid for x-rays is for professional analysis only. The films themselves remain the property of this office. The patient may check out X-ray films, however, as one does books from a library.

As a courtesy to you, this office will *verify* insurance coverage for you. Please make sure we have your current insurance card. We do file Medicare claims for you.

Your Chief Complaint

Are you looking for... temporary relief, corrective care, or continuation of wellness care ?

Reasons for visit: Wellness Care Nutrition Exercise Posture Neck pain Headaches
 Mid-back Low back TMJ Wrist Leg Shoulder Knee
 Ankle Elbow Foot Stress management Other _____

How did your main problem appear? Gradually, Suddenly, Accident/trauma, Do not know

How much is your problem present...? 100%, 75%, 50%, 25%, Less than 25% of the time

Is your problem getting worse...? Better, Worse, Staying the same

When is your problem worse...? Morning, Day, Evening, Night

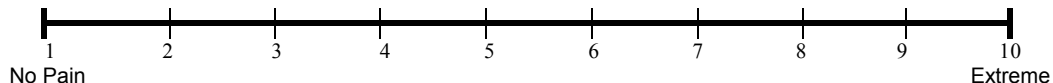
Does your problem keep you from...? Working Sleeping Your daily routine Hobbies/Play _____

Have you seen another health professional for this problem? No Chiropractor Medical

Name and city of other doctor(s) who have treated you for your condition: _____

Difficult activities: Sitting Laying down Standing Walking Bending Other

Type of pain: Throbbing Dull Sharp Numbness Aching Shooting
 Burning Tingling Cramping Swelling Other: _____



- Place a mark (X) indicating the severity of your pain or discomfort -

Health History

Please check all that apply to you; things that you have now or have had in the past.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Easily bruised | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Shaking |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Numbness | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Foot Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cardiac problems |
| <input type="checkbox"/> Abdominal Gas | <input type="checkbox"/> Skin eruptions (redness) | <input type="checkbox"/> Irritability | <input type="checkbox"/> Blood circulation problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Dizziness/ vertigo | <input type="checkbox"/> Hereditary diseases | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Back pain | <input type="checkbox"/> Eye problems |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Cold extremities | <input type="checkbox"/> Headaches | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Edema (swelling) | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fractures | <input type="checkbox"/> Operations/ Surgery | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Shivers | <input type="checkbox"/> Loss or gain of weight | <input type="checkbox"/> Hormonal problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Psychological problems |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Other: _____ | | | |

Approximate Date of Last Physical Exam: _____

Women Only:	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abundant Menstrual Flow	
	<input type="checkbox"/> Painful Menstruation	<input type="checkbox"/> No Menstruation	<input type="checkbox"/> Abdominal Cramps	<input type="checkbox"/> Menopause symptoms

Please list any surgeries and the dates they occurred: _____

Please list all medications you are currently taking None Anti-inflammatory Pain Killers
 Muscular Relaxants Hormones High Blood Pressure Diabetes "The Pill"
 Non-Prescribed medicines Other _____
Please list all known allergies: _____

Daily Habits

Do you exercise? No Yes How Much per week? >3hrs. 1 to 3 hrs. 1 hr. or less
What do your daily work habits include? Sitting Standing Moving Heavy Labor Driving
 Computer work Other: _____
What kind of vitamins do you currently take? _____
What kind of other supplements do you take? _____
Do you smoke? Yes No How much per day? _____
How much alcohol do you consume on a weekly basis? _____
How much caffeine do you consume on a daily basis? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge and that the questions have been accurately answered. I understand that providing incorrect or inaccurate answers can be harmful to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to my child or to me during the course of such chiropractic care to third party payers and/or healthcare practitioners. If accepted, I authorize and request my insurance company to pay directly to the chiropractor, or chiropractic group, insurance benefits otherwise payable to me. I further understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of patient (or parent or guardian if a minor)

Date

CHIROPRACTIC ORIENTATION

When an individual seeks, and is accepted for chiropractic health care, it is essential for both the Doctor and the seeker to be working towards the same clear goals and objectives.

Chiropractic has only one objective: to eliminate misalignments within the spinal column that interfere with the transmission of nerve impulses between the brain and the body. It is important that each practice member understands this goal and the methods used, as a team, to achieve it. This will prevent any confusion or disappointment.

GENERAL DEFINITIONS:

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: a misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those non-chiropractic findings, we will recommend that you seek the services of a health-care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate nerve interference, which is one of the primary obstacles to the body's expression of healing. Our principle method is specific adjusting of the atlas and other spinal vertebrae and/or adjacent skeletal structures to correct vertebral subluxations. We may incorporate other methods for soft tissue management such as Trigger Point Therapy, Low Level Laser Therapy, and/or nutritional counseling. Specific chiropractic adjustments allow your body to take care of the named disease or problem(s) naturally, as designed by God.**

I, _____, have read and fully understand the above statements.

Signature

Date

Parents or Guardians:

I hereby grant permission to Atlas Chiropractic of Cary to perform any necessary tests on my minor child, and to render care for said child. I acknowledge that I am the parent or legal guardian of the child listed on this form.

Signature

Date

PATIENT'S CONSENT

I, _____, hereby grant to Atlas Chiropractic of Cary permission to call my home, cell, and work numbers &/or to email me for appointment reminders and routine office needs regarding my account.

I hereby consent for Atlas Chiropractic of Cary to leave any messages for appointments, changes in schedule, and routine office needs with the following family members:

_____	Relation:	_____
_____	Relation:	_____
_____	Relation:	_____
_____	Relation:	_____
_____	Relation:	_____

I hereby deny permission for any information to be given to the following family members regarding any routine office needs here at Atlas Chiropractic of Cary:

_____	Relation:	_____
_____	Relation:	_____
_____	Relation:	_____
_____	Relation:	_____
_____	Relation:	_____

Due to the privacy act created by the Centers for Medicare and Medicaid, our office is required to collect your signature, allowing us to treat you. If you would like to have the details pertaining to the Health Information Portability and Accountability Act (HIPAA), please ask the receptionist for the Notice of Privacy Practices.

"I have read and understand the notice of privacy practices and hereby give my consent to this office to attend to me according to the usual and customary practices contained therein."

Patient Name, printed

Date

Patient's, Parent's, or Guardian's Signature