Date of Injury/Onset of Complaint: _____/_____/______

Chief Complaint: ____

How did this injury occur? ____

What treatment have you had for this? ____
____

Previous Doctors treating this condition: ____

PAST MEDICAL HISTORY Please check:

Diabetes	Yes ( ) No ( )	Sleep Apnea	Yes ( ) No ( )
HIV Positive	Yes ( ) No ( )	Cardiac Condition	Yes ( ) No ( )
Hypertension	Yes ( ) No ( )		

Other ____

Family Medical Doctor

Name ____

Address____

Past or Present Chiropractor

Name ____

Address____

Prior Car Accidents

Date ____

Injuries ____

Prior Injuries

Date ____

Part of Body____

Hobbies and Sports

____

PAST SURGICAL HISTORY : ____

MEDICATIONS :____

ALLERGIES : ____

Are you presently working? Yes ( ) Full Duty ( ) Light Duty ( )
No ( ) If no, when did you stop working? _______

Have you ever had a similar injury or symptoms in the past: Yes ( )
No ( ) When? ____

SOCIAL HISTORY Please check:

Smoking: Yes ( ) No ( ) If yes, how much? _________________
Alcohol: Yes ( ) No ( ) If yes, how often? _________________
Non-Prescription Drug Use: Yes ( ) No ( ) If yes, how often? _________________

MARITAL STATUS:

Please Circle: Single/Married/Divorced/Partner Children: Yes ( ) No ( ) Ages:____________

PARENT STATUS

Father: Alive **Yes( ) No ( )** If deceased, age and cause: ______________________________
Mother: Alive **Yes( ) No ( )** If deceased, age and cause: ______________________________

REVIEW OF SYSTEMS

YOU MUST CHECK YES OR NO

Do you have or have had any of the following:

	YES	NO		YES	NO
Chest Pains	( )	( )	Shortness of Breath	( )	( )
Seizures	( )	( )	Hypertension	( )	( )
Stroke	( )	( )	Depression	( )	( )
Heart Attack	( )	( )	Mood Disorders	( )	( )
Liver Disease	( )	( )	Incontinence	( )	( )
Kidney Disease	( )	( )	Bleeding or Blood Disorder	( )	( )
Lung Disorder	( )	( )	Problems Swallowing	( )	( )

Do you have any other disease, condition or problem not mentioned above? Please explain:

____
____

FAMILY HISTORY

Please check: Is there any family history of:

Diabetes	**Yes( ) No ( )**	Hypertension	**Yes( ) No ( )**
Heart Disease	**Yes( ) No ( )**	Cancer	**Yes( ) No ( )**
Arthritis	**Yes( ) No ( )**	Bleeding	**Yes( ) No ( )**
Allergy to anesthesia	**Yes( ) No ( )**	Clotting	**Yes( ) No ( )**

I authorize the release of medical information, when necessary, to process insurance claims. In the event my insurance denies any claim, I understand I am responsible for any expenses incurred.

Signature: ________________________(Parent's signature if the patient is a minor)

I authorize my insurance company to pay my benefits directly to Atlantic Spine Specialists if I have an outstanding balance on my account. I realize that I am responsible for payment in full.
Signature: ________________________(Parent's signature if the patient is a minor)