Welcome to AOC
Health and Wellness Center

Please print clearly and fill in both sides completely

PATIENT INFORMATION

Print Full Name:_____ Name you go by: _____Today's Date:_____
Street Address: _____ City: _____ State:_____ Zip: _____
Age:_____ Date of Birth: _____Social Security #: _____Email: _____
Please Check: (✓) Gender: Male ☐ Female ☐ Left handed ☐ Right Handed ☐ Married ☐ Single ☐ Other ☐ # of children: ___

Who/What can we thank for your visit to out office?_____
☐ Current Patient:_____ ☐ AOC web site ☐ Other internet source ☐ Drive by / sign
☐ Other _____

HEALTHCARE INTEREST

We offer a variety of services at AOC, inc. Please let us know what areas you are interested in obtaining more information:
☐ Chiropractic ☐ Kinesiology ☐ Biofeedback ☐ Custom Fit Shoe Orthodics ☐ Range of Motion Analysis ☐ Massage ☐ Pilates

CONTACT METHODS / PHONE NUMBERS

Home: _____ Work: _____ Cell: _____
Email: _____
Best time and place to reach you: _____
In case of emergency, notify: _____ Relationship: _____ Phone: _____

INSURANCE

Do you have medical insurance? Yes ☐ No ☐ Insurance Company Name: _____
Do you have Med Pay on your Automobile Insurance policy? Yes ☐ No ☐ I dont know ☐ What is Med Pay ☐

HEALTH HISTORY

Reason for seeking chiropractic care: _____

_____

Is this condition due to an accident or injury? Yes ☐ No ☐ Date: _____ Type of accident: Auto ☐ Home ☐ Other ☐

IF THIS WAS AN AUTO OR WORK ACCIDENT, PLEASE STOP AND ASK FOR DIFFERENT FORMS TO FILL OUT

Is your condition getting worse? Yes ☐ No ☐ Does it interfere with your: Work ☐ Sleep ☐ Daily routine ☐ Exercise ☐
Describe any health conditions, including treatment and initial diagnosis date: _____

_____

Are you under the care of any other doctor? Yes ☐ No ☐ Family Doctor: _____ Phone: _____
If Yes, the condition being treated for: _____
List any past surgeries and dates: _____
List any past accidents (major and minor) and dates: _____

Exercise: None ☐ Weekly ☐ Daily ☐ Heavy ☐ Light ☐ Do you sleep on your stomach? Yes ☐ No ☐ Sometimes ☐

(Please complete other side)

Medications you now take *(If you need more space, please ask for additional medication sheet):

Name	Use	Dosage	Other Comments

WORK AND FAMILY HISTORY

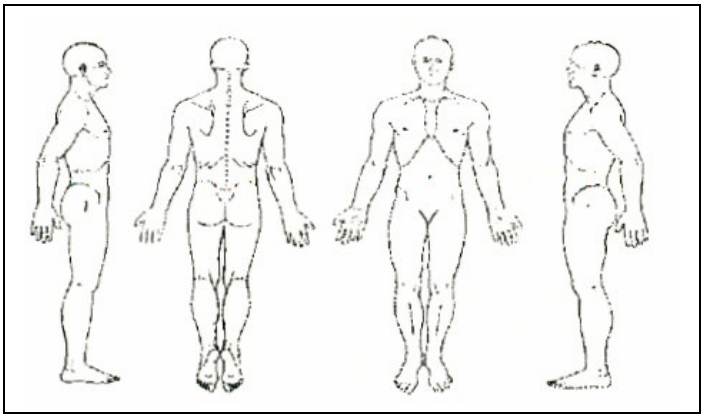
Employer: _____ Your Occupation: _____
Work Duties: _____
Is most of your day spent: sitting ☐ standing ☐ walking ☐ other ☐ (specify) _____
Spouse's occupation and health status: _____
Children's ages and health status: _____
Past or present health problems of parents & siblings: _____

CHIROPRACTIC HISTORY

Have you ever been to a chiropractor before? Yes ☐ No ☐ Date of last chiropractic visit: _____
Reason for care: _____ How long were you under care? _____
Are other family members under chiropractic care? Yes ☐ No ☐ Who? _____

Conditions, Symptom, or Problem	Constantly or Frequently	Sometimes or Occasionally	Conditions, Symptom, or Problem	Constantly or Frequently	Sometimes or Occasionally
Headaches	☐	☐	Asthma	☐	☐
Migraines	☐	☐	Breathing Difficulties	☐	☐
Neck Pain	☐	☐	Upper Back Pain	☐	☐
Shoulder/Arm/Hand Pain	☐	☐	Heart Problems	☐	☐
Dizziness	☐	☐	Mid Back Pain	☐	☐
Nausea	☐	☐	Digestive Problems	☐	☐
Earaches	☐	☐	Hip Pain	☐	☐
Allergies	☐	☐	Leg/Foot Pain	☐	☐
			Upper Back Pain	☐	☐
Joint Pain	☐	☐	Heart Problems	☐	☐
Urinary Problems	☐	☐	Mid Back Pain	☐	☐
Low Back Pain	☐	☐	Digestive Problems	☐	☐
Disc Problems	☐	☐	Hip Pain	☐	☐
Arthritis	☐	☐	Leg/Foot Pain	☐	☐
Female Problems	☐	☐	Numbness/Tingling	☐	☐
Male Problems	☐	☐	Joint Pain	☐	☐
Cancer	☐	☐	Urinary Problems	☐	☐
Osteoporosis	☐	☐	Low Back Pain	☐	☐
Diabetes	☐	☐	Frequent Colds	☐	☐
Hepatitis	☐	☐	Insomnia	☐	☐

Place an "X" on the diagram below where you have any pain, numbness, tingling, or other problems.



Below, please fill out any other health information you feel we might need to know for your care.

_____
_____
_____
_____
_____

Consent for treatment: I (WE) request and consent to the performance of chiropractic adjustments and to other chiropractic procedures on me or _____(child's name), _____ (relationship to the child), by any chiropractor in this office. I have also been advised that there are other risks, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. This practice will not be held responsible for any pre-existing medically diagnosed conditions, nor will it be held responsible for any medical diagnosis. If your condition involves the detection of color difference determination, then I understand that I must go to a different clinic, because the doctors of this clinic do not see colors well. I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below agree to all procedures.
Authorization for X-rays: I hereby authorize the doctors of Atlas Orthogonal to treat my condition as they deem appropriate through the use of adjustments, x-rays, and other chiropractic procedures throughout my spine. It is understood and agreed the amount paid the clinic, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.
Billing Responsibility / Assignment of Benefits: The patient also agrees that he/she is responsible for all bills at this office. I hereby instruct and direct my insurance company to pay by check made out and mailed directly to AOC or the Doctor for the professional or medical expense benefits allowable. A photocopy of this assignment shall be considered as effective as valid as the original**.** This is a direct assignment of my rights and benefits under my rights and benefits under this policy as payment toward the total charges for services rendered at AOC. AOC is authorized to release information deemed appropriate considering my physical condition to any insurance company, attorney or adjuster in order to process claims for reimbursement of charges incurred as a result of services rendered by AOC and I hereby release AOC of any consequences thereof, I authorize the doctor to inititate a complaint to the Insurance Commissioner for any reason on my behalf. I understand that I am personally responsible for all attorney fees, collection fees and interest (18% per annum) for expenses related to the recovery of money owed.

PATIENT'S SIGNATURE _____ DATE _____

FEMALE PATIENTS: To the best of my knowledge, I am **NOT** pregnant and the doctors of Atlas Orthogonal Chiropractic have my permission to x-ray me for diagnostic interpretation.

PATIENT'S SIGNATURE _____ DATE _____