



ATKINSON FAMILY CHIROPRACTIC, P.C.

BRYAN C. ATKINSON, D.C.

2830 E. Brown Rd. Suite C-11 Mesa, AZ 85213 (480) 324-1000

safe and natural treatment of neck and back pain, joint pain, headaches, scoliosis, and compression trauma

APPLICATION FOR EXAMINATION/TREATMENT Of A Minor

I. Patient Care

Please check the type of care desired; Relief Care ____, Corrective Care ____ or
Dr. Recommended Level of Care ____

REFERRED HERE BY?: _____

II. Patient Information

A. Personal

NAME: Mr./Ms. _____ DOB: __/__/__
(first) (middle) (last)

SOCIAL SECURITY NUMBER: _____ - _____ - _____

HOME ADDRESS: _____ CITY: _____ STATE: ____

ZIP: _____ - _____ HOME PH. (____) _____ - _____

E-MAIL ADDRESS _____ @ _____

Mothers name: _____ Fathers name: _____

MARITAL STATUS OF PARENTS: MARRIED, SINGLE, DIVORCED or SEPARATED?

Who has legal custody of the child? Mother, Father, Shared, Other: _____

IF THE CHILD HAS SIBLINGS PLEASE LIST THEIR NAMES AND AGES?

_____, _____, _____
(), (), ()
_____, _____, _____
(), (), ()

B. EMPLOYMENT OF PRIMARY PARENT Mother/Father

NAME: Mr./Ms. _____ DOB: __/__/__
(first) (middle) (last)

Company Name: _____ Occupation (describe): _____

Address: _____ City: _____ State: _____ ZIP: _____

Ph.: (____) _____ Ext. _____ Full time/ Part time

C. INSURANCE

Health Insurance Co. (Name): _____ Phone: _____

Policy #: _____ Employee #: _____

III. SPOUSE

Name of Spouse: _____ DOB: __/__/__

SOCIAL SECURITY NUMBER: _____ - _____ - _____

HOME ADDRESS: _____ CITY: _____ STATE: ____

ZIP: _____ - _____ HOME PH. (____) _____ - _____

Cell Phone/Pager: (____) _____

Company Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ ZIP: _____

Ph.: (____) _____ Ext. _____ Full time/ Part time

Health Insurance Co. (Name): _____ Phone: (____) _____ - _____

Policy #: _____ Employee #: _____

Patient Name: _____

IV. EMERGENCY NOTIFICATION

Your closest friend or relative to contact in case of an emergency

Name: _____ Relationship: _____
(first) (middle) (last)

HOME ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ Hm. Ph. (____)____-____ Cell Ph. # (____) _____-

Place of Employment: _____ Bus. Ph.: (____) _____-

V. FINANCE

Fees Are Payable At Time Of Consultation, Examination, Laboratory, Diagnostic Imaging (X-RAY), Treatment Or When Other Services Are Performed. Exceptions Must Be Made In Advance. X-RAY Films Remain The Property Of Your Medical File And Need To Remain At This Clinic. Films Will Be Made Available For Loan To Other Healthcare Facilities Or Copies Will Be Made Available Upon Request And Advance Payment Of The Copy Fee.

Who Will Assist You In Paying For Your Care?

Self ___ Spouse ___ Employer ___ Insurance ___ Other _____

How Will Payment Be Made? Cash ___ Check ___ Health Ins. ___ Auto Ins. ___

Other: _____

PATIENT'S SIGNATURE: _____ DATE: ____/____/____

(Self/Legal Guardian)

VI. AUTHORIZATIONS

I Authorize Communications Between _____ Insurance Company and/or Attorney's Office And Atkinson Family Chiropractic, PC. I Also Authorize Said Insurance Company and/or Attorney's Office To Make Benefit Payments Directly To Atkinson Family Chiropractic, PC For Services Relating To My Medical Claim/File.

I Understand, As With Any Medical Examination Or Procedure, There Are Inherent Risks To Examination And Care With Chiropractic Medicine. The Doctor Has Explained These Risks And Options To My Satisfaction. With This Understanding, I Accept These Risks. Initials: _____

Claims Past 90 Days Due Will Be Charged 1.5% Or \$5 Per Month Late Fee, Which Ever Is Greater. Claims Past 120 Days Due Will Be Sent To Collections. The Patient/Responsible Party Will Incur All Fees And Expenses Associated With This Process.

PATIENT'S SIGNATURE: _____ DATE: ____/____/____

(Self/Legal Guardian)

Information Taken By: _____

(Office Staff)

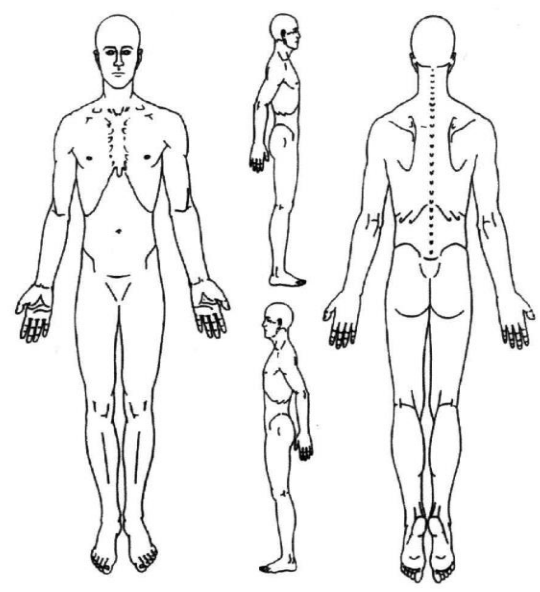
Patient Name: _____

Please list your symptoms below and the relative pain intensity (0 – 10) for each symptom. (Example: Low back pain – 4)

| | No Pain | Mild | Moderate | Severe | Unbearable | | | | | | |
|----------|---------|------|----------|--------|------------|---|---|---|---|---|----|
| 1) _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2) _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3) _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4) _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5) _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 6) _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 7) _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 8) _____ | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Please mark on the diagram to the right with the following symbols as they relate to your symptoms location and description:

- SS = spasms ST = stiffness DP = dull pain SP = sharp pain
SH = shooting pain TI = tingling NU = numbness O = Other



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

When were you first aware of the problem? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

Over all, has this been getting ___worse? ___better? ___staying the same?

How has this affected your life?

Home: _____

Occupation: _____

Recreation: _____

Rest and Sleep: _____

Have you ever received treatment for this condition before? ___Yes ___No

If yes, When, Where, and What were your results? _____

Doctors you have consulted with in the past for this problem:

Name: _____ Ph. (____) _____

Name: _____ Ph. (____) _____

Do you have a family Dr.? Name: _____

Contact information: Ph. (____) _____ Address: _____

Patient Name: _____

Have you ever been involved in a motor vehicle accident? Y N When? 1____ 2____ 3____
Hit from: Front/Back Right side/Left side? Any injuries? _____

Do you know what may have caused your problem? Accidents, falls, etc.: _____

Have you had any surgeries? _____

Are you currently taking medication? Heart, Birth Control, Diabetes, Pain....?

Name of Rx: _____ For condition: _____

Name of Rx: _____ For condition: _____

Name of Rx: _____ For condition: _____

Name of Rx: _____ For condition: _____

Check any of the following symptoms you currently have or have experienced in the past 2 weeks:

- | | | |
|--|---|---|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Head Seems Heavy | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Spasms | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Decreased Range of Motion | <input type="checkbox"/> Feet Hot/Cold | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hands Hot/Cold | <input type="checkbox"/> Teeth Grinding |
| <input type="checkbox"/> Visual Disturbances | <input type="checkbox"/> Pins/Needles in Hands/Arms | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Radiating Pain | <input type="checkbox"/> Pins/Needles in Feet/Legs | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Numbness in Hands | <input type="checkbox"/> Arm or Hand Pain |
| <input type="checkbox"/> TMJ dysfunction | <input type="checkbox"/> Numbness in Feet | <input type="checkbox"/> Leg or Foot Pain |
| <input type="checkbox"/> Hearing Changes | <input type="checkbox"/> Chest Pain /or Pace Maker | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Back Stiffness |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> No Symptoms at all |

Symptoms other than listed above? _____

Is your pain constant? Yes No, Where? _____

Is your pain intermittent? Yes No, Where? _____

Is your pain sharp? Yes No, Where? _____

Is your pain dull? Yes No, Where? _____

Other description? _____

What is your most comfortable position (D=Day, N=Night)? Sitting Standing
 On Back On Stomach On Right Side On Left Side Other: _____

- | | |
|---|---|
| Difficult to move around in bed? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | Knee Problems? <input type="checkbox"/> Yes/ <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left |
| Difficult to Stretch or Twist? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | Cramps? <input type="checkbox"/> Yes/ <input type="checkbox"/> N Where? _____ |
| Do you feel better moving around? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | Any Recent Change In <input type="checkbox"/> Bowels? <input type="checkbox"/> Bladder? |
| Do you feel better Resting? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | and/or <input type="checkbox"/> Reproductive System(s)? None |
| Have you tried a brace? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | Are you able to take care of your own personal |
| Heel height change your pain? <input type="checkbox"/> Yes/ <input type="checkbox"/> No | needs? Eating, Bathing, Dressing: <input type="checkbox"/> Yes/ <input type="checkbox"/> No |

Patient's Signature: _____ Date: _____ Phys: _____



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Providing Quality Service For Over 25 Years!

PATIENT'S AFFIRMATION OF RECEIPT OF PATIENT'S NOTICE OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Patient's Notice of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

This document can be reviewed online at www.afcmesa.com, under the "New Patient Center" tab, "Online Forms" page.

Affirmed,

Patient Name (or legal guardian)

Date