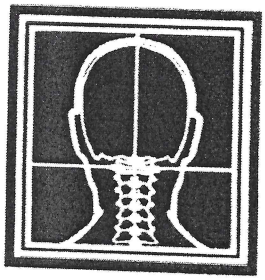
Dr. Mark Van Doren
ATLAS Orthogonal Chiropractic
760.730.9999



New Patient Intake Form

Title: (Mark one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other

First Name _____ Middle Initial ___ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Social Security Number: _____ - ___ - _____ Sex: ☐ Male ☐ Female

Date of Birth _____ / _____ / _____ Marital Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student ☐ Other _____

Employer Data

Employer _____

Your Occupation _____

Spouse Data

First Name _____ Middle Initial ___ Last Name _____

Home Phone _____ Work Phone _____

Spouse Date of Birth _____ / _____ / _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone _____ Cell Phone _____

Doctor's Signature _____

SYMPTOM SURVEY

NAME _____ **DATE** _____

1. GENERAL SYMPTOMS: (Circle as many as apply)

A) Nervousness B) Irritability C) Fatigue D) Depression
E) Loss of Sleep F) Tension G) PMS H) Jaw Pain

2. HEAD: (Circle as many as apply)

A) Headache 1) Mild 2) Moderate 3) Severe
How often: (1 2 3 4 5 6 7) Per (Day / Wk / Mo)
Are they: 1) Sharp 2) Dull
Are they: 1) Constant 2) Intermittent
Where Located: 1) Back of Head 2) Forehead
3) Temple 4) Right Side
5) Left Side 6) Behind Eyes
B) Light Headed C) Memory Loss D) Fainting
E) Blurred Vision F) Double Vision G) Sensitivity to Light
H) Loss of Balance I) Hearing Loss J) Ringing in Ears

3. NECK: (Circle as many as apply)

A) Pain 1) Left Side 2) Right Side 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
Pain Increased by 1) Forward Movement
2) Backward Movement
3) Rotate Head Rt 4) Rotate Head Lt
5) Bend Neck Rt 6) Bend Neck Lt
B) Stiffness C) Muscle Spasm D) Grinding/Grating Sounds

4. SHOULDERS: (Circle as many as apply)

A) Pain in Joint	1) Left	2) Right	3) Both
B) Pain Across Shoulder	1) Left	2) Right	3) Both
C) Limitation of Movement	1) Left	2) Right	3) Both
D) Tension	1) Left	2) Right	3) Both

5. ARMS: (Circle as many as apply)

A) Pain in Upper Arm	1) Left	2) Right	3) Both
B) Pain In Elbow	1) Left	2) Right	3) Both
C) Pain in Forearm	1) Left	2) Right	3) Both
D) Pins & Needles (Arm)	1) Left	2) Right	3) Both
E) Pins & Needles (Forearm)	1) Left	2) Right	3) Both
F) Numbness in Arm	1) Left	2) Right	3) Both
G) Numbness in Forearm	1) Left	2) Right	3) Both

6. HANDS: (Circle as many as apply)

A) Pain in Wrist	1) Left	2) Right	3) Both
B) Pain in Hand	1) Left	2) Right	3) Both
C) Pins & Needles (Hand)	1) Left	2) Right	3) Both
D) Numbness (Hand)	1) Left	2) Right	3) Both

7. MIDBACK: (Circle as many as apply)

A) Pain 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
Pain Type 1) Sharp/Stabbing 2) Dull Ache
B) Muscle Spasm 1) Left 2) Right 3) Both

8. CHEST: (Circle as many as apply)

A) Deep Chest Pain 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
B) Pain Around Ribs 1) Left 2) Right 3) Both
C) Shortness of Breath
D) Irregular Heartbeat

9. ABDOMINAL SYMPTOMS: (Circle as many as apply)

A) Pain Level 1) Mild 2) Moderate 3) Severe
B) Nervous Stomach C) Heartburn D) Gas E) Constipation
F) Diarrhea G) Nausea H) Indigestion I) Loss of Appetite

10. LOW-BACK: (Circle as many as apply)

A) Upper Lumbar Pain	1) Left	2) Right	3) Both
B) Lower Lumbar Pain	1) Left	2) Right	3) Both
C) Sacroiliac Pain	1) Left	2) Right	3) Both
D) Muscle Spasm	1) Left	2) Right	3) Both
Low Back Pain Level	1) Mild	2) Moderate	3) Severe

11. HIPS AND LEGS: (Circle as many as apply)

A) Pain in Buttocks	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Severe
B) Pain in Hip Joint	1) Left	2) Right	3) Both
Pain Level	1) Mild	2) Moderate	3) Severe
C) Pain Down Leg	1) Left	2) Right	3) Both
Location	1) Front	2) Back	3) Side
Pain Radiates to	1) Knee	2) Calf	3) Foot
D) Numbness Down Leg	1) Left	2) Right	3) Both
Location	1) Front	2) Back	3) Side
E) Pins & Needles (Legs)	1) Left	2) Right	3) Both
Location	1) Front	2) Back	3) Side
F) Knee Pain Leg	1) Left	2) Right	3) Both
G) Leg Cramps	1) Left	2) Right	3) Both

12. FEET: (Circle as many as apply)

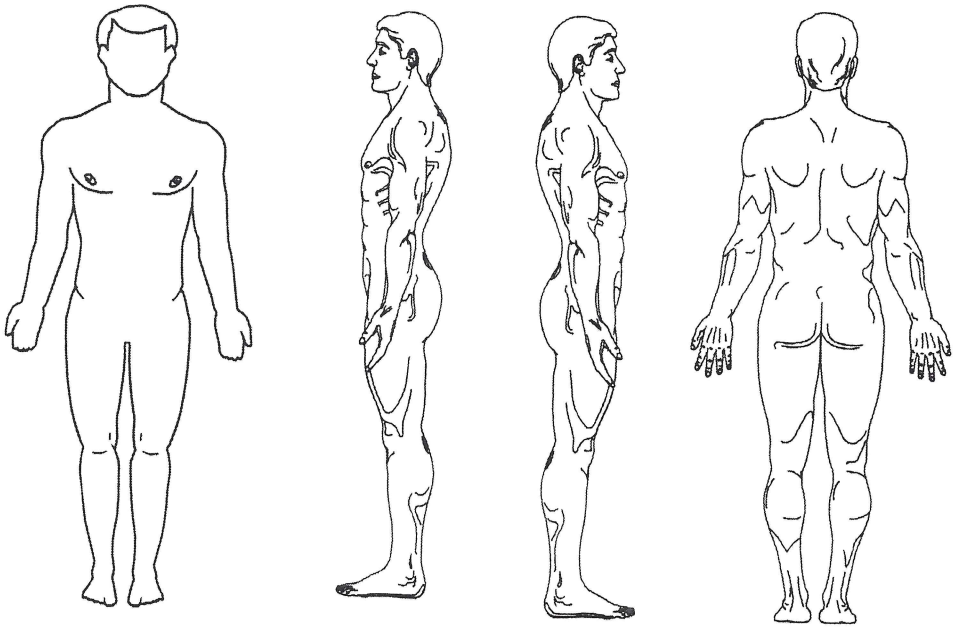
A) Ankle Pain	1) Left	2) Right	3) Both
B) Swollen Ankle	1) Left	2) Right	3) Both
C) Foot Pain	1) Left	2) Right	3) Both
D) Numbness of Feet	1) Left	2) Right	3) Both
E) Swollen Feet	1) Left	2) Right	3) Both
F) Cramps	1) Left	2) Right	3) Both

SYMPTOM SURVEY *(continued*

NAME _____ **DATE** _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

N=Numbness **B**=Burning **S**=Sharp T=Tingling **A**=Dull Ache



Average Pain Intensity:

Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:**

When did your symptoms begin?

Are your symptoms a result of: ☐Motor Vehicle Accident ☐Work related Accident ☐Other_____

How did your symptoms begin? _____

_____

How often do you experience your symptoms?

☐Constantly (76-100% of the day) ☐Frequently (51-75% of the day) ☐Occasionally (26-50% of the day) ☐Intermittently (0-25% of the day)

What describes the nature of your symptoms?

☐Sharp ☐Ache ☐Numb ☐Shooting

☐Burning ☐Tingling ☐Throbbing ☐Other _____

Doctor's Signature _____

Patient's Signature _____ Date _____

Dr. Mark Van Doren
ATLAS Orthogonal Chiropractic
760.730.9999

CHIROPRACTIC INFORMATION CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor indicated above and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named above, including those who working at the clinic or office listed above or any other office or clinic, whether signatures to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self-administration, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other if I have concerns as to the nature of my symptoms and treatment options.

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 I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date _____
(or patient Guardian/Representative, provide name and relationship if signing for patient)