ATLAS PAIN INSTITUTE

(512) 332-2777 ● 85 Loop 150 West Bastrop, TX 78602 ● www.atlaspaininstitue.com

Patient Registration Information

Date:

How did you decide to come to our office? €Newspaper € Yellow Pages € Website € Referred By:__________________

Is your visit due to an accident? € Yes € No Age:____ Date of Birth:____________ Gender: ______

Name:_________________ Address:___________________ City: _____________ State: TX Zip Code: ________

Cell Ph#: _________________ Cell PROVIDER for text reminders _____________________Home Ph: ____________________

Email: _________________________ SSN: _______________________ D.L. ________________

Employer: ____ Work Ph: ____________________

_____ Spouse:________________________ Ph #___________________

Employer____________________Ph#:___________________

Name of nearest relative (other than spouse) ____Ph#: ______________________

In case of emergency contact: ____ Ph#: ______________________

PRESENT COMPLAINT - Describe Your Pain:

____

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____

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When did the pain start? ___________________________________

What makes the pain better? Sitting standing laying down walking nothing other:_______________________

What makes the pain worse? Sitting standing laying down walking nothing other:_______________________

What have you done for the pain? Pain killers Ice heat aspirin nothing other: ____________________________

Other doctors seen for this problem:____

Other treatment & results:____

Hospitalized: €Yes €No How many days:________ # of days missed from work/school:________

HEALTH HISTORY:

__polio	__diabetes	__rheumatism	__Scarlet Fever	__Digestive Disorders
__Anemia	__Hepatitis	__Concussion	__Heart Trouble	__High Blood Pressure
__Asthma	__Arthritis	__Convulsions	__German Measles	__Muscular Dystrophy
__Cancer	__Dizziness	__Nervousness	__Rheumatic Fever	__Other_______________________
__Neuritis	__Numbness	__Tuberculosis	__Venereal Disease	
__Epilepsy	__Backaches	__Sinus Trouble	__Multiple Sclerosis	

Surgeries & Dates: ____

Treated by a physician for any condition in the last 12 months? € Yes € No Describe:____________________________________

Date of last physical exam: ______________Pregnant: € Yes € No Date of last menstrual period:_________________________

Patient Signature: ____ Date:_____________________