

Atlanta Natural Health

Adult Intake Form

First Name: _____ MI: _____ Last Name: _____
 Date of Birth: _____ Prefer to be called: _____
 Address: _____ City/State/Zip _____
 Primary Phone: _____ Other Phone: _____
 E-mail: _____ SS#: _____
 Gender: () male () female () _____ () prefer not to disclose Marital Status: S M D W
 Preferred language: () English () Spanish () _____ Partner's Name: _____ # of children: _____
 Occupation: _____ Employer: _____
 Have you ever received a Chiropractic Adjustment? () Yes () No How long ago? _____
 By whom? Where? _____
 Please tell us who referred you to our office: _____

YOUR HEALTH PROFILE

The focus in our office is your health. Our goals are, first, to address the issues that brought you to our office, and second, to offer you the opportunity of improved health potential and wellness service in the future. On a daily basis, we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual; not even felt until they have become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the changes that have occurred and ultimately challenge your health potential; please answer them to the best of your ability.

YOUR CHILDHOOD YEARS

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth.

Yes	No	Not Sure	(Please check the appropriate box and circle to indicate present/previous where appropriate)	Please explain
			Was your birth difficult? (forceps, cesarean, breech, epidural, etc.)	
			Did you have major childhood illness?	
			Did you have any serious falls or injuries (including fractures)?	
			Did you take/use any prescription, over the counter or recreational drugs? Any side effects?	
			Did you have any surgeries?	
			Did you suffer from any other traumas (physical or environmental including car accidents)?	

			Were you vaccinated?	
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ADULT YEARS

Yes	No	(Please check the appropriate box and circle to indicate present/previous where appropriate)	Please Explain
		Did/do you smoke? How much and how often?	
		Have you had any motor vehicle accidents, fractures, or surgeries?	
		Did/do you play any sports? Extreme sports?	
		Did/do you take any prescription or over the counter drugs frequently?	
		Did/do you use recreational drugs (including alcohol)?	
		Do you still follow up with your vaccinations?	

Addressing Your Current Condition (Why are you here?)

Please briefly describe the chief area of complaint and the effect it is having on your life:

___ If you have no symptoms or complaints, and are here for wellness services, please check here

If you are experiencing pain, is it: (please mark all that apply)

___ Sharp ___ Dull ___ Achy ___ Stabbing ___ Gnawing ___ Burning ___ Numb ___ Tingling
 ___ Comes & goes ___ Constant ___ Constant

Since the problem started, is it: ()getting worse ()getting better ()about the same

When did it start? _____ What makes it worse? _____

What makes it better? _____ What other doctors have you seen for this? _____

Current medications: _____

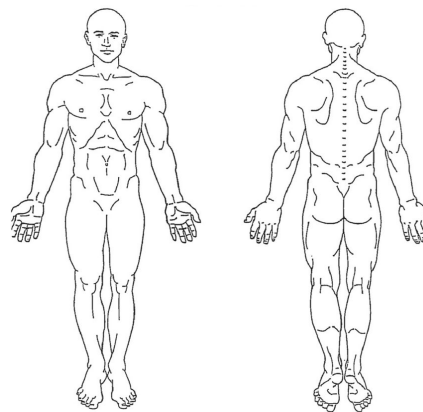
Please mark "1" for current issues, "2" for recent issues, and "3" if you have ever experienced:

	Headache		Depression		Anxiety		Heart condition
	Facial pain		Meningitis		Stroke		Scoliosis
	Jaw pain		Dizziness		Upset stomach		Cancer
	Heartburn/acid reflux		Difficult or painful urination		COPD or emphysema		Diabetes (specify type I or II)

	Numbness in arms or legs	Numbness in fingers or toes	Buzzing or ringing in ears	High blood pressure/hypertension
	Cold sweats	Menstrual pain	Loss of balance	Chest pain
	Trouble sleeping	Frequent urination or strong urge	Menstrual irregularity	
	Loss of smell	Asthma	Loss of taste	

Poor	Good	Excellent	
			Diet
			Exercise
			Sleep
			General Health

Where is your pain?



_____ I don't have any pain

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual period: _____

_____ signature

_____ date

Consent to evaluate and adjust a minor / child

I, _____ being the parent or legal guardian of _____ have read and fully understand the attached terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ Signature

_____ date

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4633 Buford Highway, Atlanta GA 30341

www.AtlantaNaturalHealth.com

770-455-6767

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights *concerning* those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and *agree* with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent .

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to *privacy*, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. In this office, we have a semi-open adjustment setting, so there is a possibility of another individual hearing private health information. Patients have the right to request a private consultation and/or adjustment in a closed office if they object to this.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

signature

date

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Every type of health care is associated with some risks, including chiropractic care. We want you to be informed about potential problems associated with chiropractic care before consenting to treatment. This is called informed consent.

HEALTH: A state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 33 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

ADJUSTMENT: Chiropractic adjustments are the specific application of forces to facilitate the body's correction of vertebral subluxation. This is accomplished by use of the doctor's hands or use of an adjusting instrument. Often, those movements result in a "pop" or "click" sound and/or sensation in the area being adjusted.

In this office we may use trained staff personnel to assist the doctor with portions of your consultation, examination, x-rays, exercise instruction, or other services. Occasionally, when your doctor is unavailable, another doctor will adjust you on that day.

STROKE: Stroke is the most serious potential problem which may be associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen for the bloodstream. The result can be temporary or permanent dysfunction of the brain or even death. Chiropractic adjustments may only be associated with the vertebral artery, and recent research has indicated that first, the vast majority of strokes that occur are from the carotid artery (not the vertebral), and second, that the risk of stroke in a chiropractic office is the same as it would be in a medical office, a yoga class, or a hairdresser. If that still doesn't sit right with you, a major study from 1993 indicated that a vertebral artery stroke occurs in 1 per every 3,00,000 adjustments to the upper neck. This means a chiropractor would have to practice for hundreds of years to be statistically associated with a single patient stroke.

SORENESS: It is possible for chiropractic adjustments or other modalities to result in an increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous and may vary according to your general health. Drinking more water after your adjustment may help prevent soreness.

The statements below this sentence generally incur problems so rarely that there are no available statistics to quantify their probability.

SOFT TISSUE INJURY: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, an adjustment, traction, massage therapy, therapeutic exercise or other procedure may damage some muscle or ligament fibers. The result is a temporary increase in pain which may necessitate extra visits for resolution, but there are no long-term effects for the patient.

RIB FRACTURES: The ribs extend from the base of your neck to the start of your lower back and from the spine to the center of your chest. Rarely, a chiropractic adjustment may "crack" or fracture a rib bone. This occurs only in patients who have weakened bones from conditions such as osteoporosis or cancer. We adjust all patients very carefully, especially those with known osteoporosis or who are over the age of 65 or under the age of 18.

There may be other problems or complications that may arise from chiropractic care other than those noted above. These occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

CHIROPRACTIC CARE AND DIAGNOSIS: We do not offer to diagnose or treat any disease, regardless of what the disease is called. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of our examination or care we encounter non-chiropractic or unusual findings, we will notify you. If you desire advice, diagnosis, or treatment for those findings, we will recommend you seek the services of another health care provider. We will not offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expressions of the body's innate wisdom.

CHOICE: I understand that if I am wary of having any part of my spine adjusted by hand, the doctor may (at my request) use an instrument to adjust the area in question, minimizing any potential risk of injury. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who may be better able to fulfill your health needs.

I, the undersigned, have read and fully understand the above statements. All of my questions regarding my care and the doctor's objectives for my health have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Printed Name

Signature of patient/guardian

Date

FINANCIAL AGREEMENT

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you to get the best results in the shortest amount of time. The following are the most common services we provide:

PROCEDURE	PURPOSE	WHEN PERFORMED	FEE
CONSULTATION	Meet with the doctor, discuss your reasons for being here, and review your case history	First visit, new injuries, or new condition	No charge
EVALUATION / EXAM	Ascertain the nature and severity of your health problem. Assess and evaluate your new or current health status and determine and appropriate course of action	First visits, new conditions, exacerbations, and progress examinations	\$90.—\$220
DIAGNOSTIC IMAGING (X-RAYS and scans)	Visualize the location of spinal problems and confirm other exam findings.	As necessary for 1st visit, re-injuries and progress examinations	\$25. -.\$150. \$39. - \$65.
CHIROPRACTIC ADJUSTMENTS	Reduce and remove the Vertebral Subluxation	As indicated by examination	
NUTRITIONAL RESPONSE TESTING	Access any nutritional imbalances or toxins that may be contributing to or compromising your body's ability to heal and function at its optimal state	As indicated by examination and evaluation and interest of patient	\$140. Initial \$39 Follow Up
BEMER	Improvement of micro vascular function	Interest of patient	\$15 - \$20 (packages available)
NSRT / BAX	Stress reduction using Low Level Light Laser Therapy and homeopathic support.	Interest of patient	\$120 (packages available)
DETOX FOOTBATH	Stimulate detoxification processes and pull toxins from the body	Interest of patient	\$35 (1 st only \$30) (packages available)
HEALTH COACHING	Create a vision and plan for attaining the ideal expression of your authentic expression of potential.	Interest of patient	\$120 (packages available)

Forms of Payment

We accept cash, personal checks, Visa, Mastercard, Discover, Tradebank, and Equitrade. Payment is expected at time of service unless other arrangements have been made. **Billing is taken care of at the front desk unless other arrangements need to be made.**

For the convenience of our patients, services may be paid for in advance.

Special Arrangements

We have never denied anyone the benefit of care due to their inability to pay our published fees. Individual contracts can be designed to help specific financial needs. **The most important thing to us is that people are given what they need.**

Preferred Chiropractic Doctor (PCD)

ANHC is a participating provider with a national organization that legally allows us to reduce our fees for participating members. PCD membership is available to all patients. **Reduced PCD rates are only applicable when insurance reimbursement is not going to be used.** Annual membership fee is \$37.00. You can join here or online at www.bewell2.com. Under the "PCD umbrella", **discounted prepayment plans are available to PCD members**, details available at the front desk.

Product Returns

Unopened supplements may be returned for a full refund within 90 days of purchase. There is no refund on opened products.

I certify that all information provided is true and complete. I agree to pay the amount invoiced in full. I further agree to pay all costs of collection, including costs of a collection agency if the account is turned over to a collection agency, and including 15% attorney's fees and court costs in the event this balance is turned over to an attorney. It is agreed that this agreement will be governed under the law of the State of Georgia. The Atlanta Natural Health Clinic has the option of pursuing an action under this agreement in any court of competent jurisdiction in the State of Georgia and I consent to jurisdiction in the State of Georgia.

Signature of patient: _____

Date: _____