Integrative Healthcare of Atlanta

Patient Application Form

WELCOME TO OUR OFFICE. We specialize in assisting people to achieve their highest level of health through our unique and advanced protocols.

You must fill out the following information as **thoroughly** as possible so we can let you know if we accept your case.

I agree to the above terms and understand that should I NOT have the paperwork completed, I may NOT be seen. I also agree and understand that should I receive a consultation on my case as outlined in this paperwork, that Dr. Lawrence is assessing my case on the basis of her chiropractic license. I agree and understand that it is my responsibility to seek appropriate medical care in such cases.

Signature:_____

Today's Date:_____/_____/_____

PLEASE BRING THIS PAPERWORK TO THE OFFICE TO YOUR SCHEDULED APPOINTMENT OR FAX/SCAN/RETURN PRIOR TO YOUR CONSULTATION.

BE SURE TO SEND ALL CURRENT (NO MORE THAN 3 MONTHS OLD) BLOOD WORK AT LEAST 3 DAYS PRIOR TO YOUR APPOINTMENT.

YOU MAY ALSO HAVE IT FAXED TO OUR OFFICE AHEAD OF TIME FROM YOUR DOCTOR'S OFFICE.

General Information

Name:_____ Gender: M F

Home Address:_____ Home Phone:_____

City, State, Zip:_____ Work Phone:_____

Email Address:_____ Cell Phone:_____

Birth Date:____/____/____ Age:_____ Marital Status: _____

Height:_____ Weight:_____lbs. Weight gain/loss in past 18 months:_____

# of Children:_____ Ages:_____ Occupation:_____

Employer Name:_____

How were you referred to this office? _____

Due to office policy, all supplement sales are final and cannot be returned***

Purpose of this Visit

Reason for this Visit – Main Complaint:_____

When did this condition begin?___/___/___ Did it begin: **Gradual**____ **Sudden**____ **Progressive over time**___

Is there anything which has relieved your symptoms? **Yes No** Describe:_____

How often do you experience these symptoms in the day? **100% 75% 50% 25% 10% Only with activity**

Does complaint(s) interfere with**: Work Sleep Hobbies Daily Routine** Explain:_____

Have you experienced this condition before: **Yes No** If so, please explain:_____

Who have you seen for this?_____ What did they do?_____

How did you respond?_____

Reason for this Visit – Other Complaints:_____

When did this condition begin?___/___/___ Did it begin: **Gradual**____ **Sudden**____ **Progressive over time**___

Is there anything which has relieved your symptoms? **Yes No** Describe:_____

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with**: Work Sleep Hobbies Daily Routine** Explain:_____

Have you experienced this condition before: **Yes No** If so, please explain:_____

Who have you seen for this?_____ What did they do?_____

How did you respond?_____

Experience with Doctors

Have you seen a Medical Doctor for this condition: **Yes No** Who?_____ When:___/___/___

Type of Specialty:_____

How did you respond and what was recommended?_____

Did your previous doctor take X-Rays, MRI or CT Scan? **Yes No** Did you receive other diagnostic tests? **Yes No**

Type and results:_____ **(Please BRING a copy)**

Have you received any Blood Analysis/Blood testing within the past 18 months? **Yes No (Please BRING a copy**)

Have you seen a Chiropractor before? **Yes No** Who?_____ When:___/___/___

Reason for visits:_____ How did you respond?_____

Family Health History

List any health history issues in your family:_____

Family history of: **Arthritis, Rheumatoid Arthritis, Juvenile RA, Lupus, Diabetes I or II, Hashimotos, Sarcodosis, Psoriasis, Celiac, Gout, Cancer, Heart Disease.** Who and who had what?_____

_____

_____

Are your parents still living, healthy, and if not healthy, please explain details with their ages:_____

_____

_____

_____

_____

_____

_____

Please provide any other details possible on family history:_____

_____

_____

_____

_____

_____

_____

Personal Health History: Blood Born Disease – HIV, AIDS, Bleeding Disorder, Herpes, STD/STI, Gout, Hep A, B, C

_____

_____

When were you diagnosed and by whom? ___/___/___ _____

Personal Health

BRAIN AND CERVICAL:

Do You **currently** experience: (Please write "**past**" if you did experience this in the past but are not currently)

- ☐ Confusion
- ☐ Memory Loss/Forgetfulness
- ☐ Depression/Sadness
- ☐ Emotional Swings
- ☐ Anger/Frustration
- ☐ Unclear Thinking
- ☐ Mixing up data
- ☐ Difficult speech/Can't find words
- ☐ Procrastination/Disorganized
- ☐ OCD or early OCD symptoms
- ☐ Attention Deficit/Focus Issues
- ☐ Early Dementia Issues
- ☐ Difficult/Dislike Social Situations
- ☐ Anxious/Panic Attacks
- ☐ Phobias/Addictions
- ☐ Neck Pain/Soreness/Achy
- ☐ Pain in Shoulders/Arms/Hands
- ☐ Numbness/Tingling in Arms/Hands
- ☐ Hearing Disturbances
- ☐ Weakness in Grip
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual Disturbances
- ☐ Coldness in Hands
- ☐ Thyroid Conditions
- ☐ Sinusitis
- ☐ Allergies/Hay Fever
- ☐ Recurrent Colds/Flu
- ☐ Low Energy/Fatigue
- ☐ TMJ/Pain/Clicking

HEART / LUNGS / DIGESTIVE:

Do You **currently** experience: (Please write "**past**" if you did experience this in the past but are not currently)

- ☐ Heart Palpitations
- ☐ Shortness of Breath
- ☐ Heart Attack/Angina
- ☐ Mid/Upper Back Pain
- ☐ Pain into your Ribs/Chest
- ☐ Indigestion/Heartburn
- ☐ Heart Murmurs
- ☐ ANY history of Auto-Immune Disease
- ☐ Recurrent Lung Infections/Bronchitis
- ☐ Hypoglycemic Symptoms
- ☐ Diabetes/Insulin Resistance
- ☐ Tired/Irritable after eating or when you haven't eaten for a while
- ☐ Asthma/Wheezing
- ☐ Tachycardia
- ☐ Fatigue between meals
- ☐ Nausea/Vomiting
- ☐ Reflux/Ulcers

STRUCTURE:

Do You **currently** experience: (Please write "**past**" if you did experience this in the past but are not currently)

- ☐ Pain In Hips/Legs/Feet
- ☐ Numbness/Tingling in Legs/Feet
- ☐ Frequent/Difficulty Urinating
- ☐ Constipation/Diarrhea
- ☐ Recurrent Bladder Infections
- ☐ Muscle Cramps in Legs/Feet
- ☐ Coldness in Legs/Feet
- ☐ Menstrual Irregularities/Cramping (Females)
- ☐ Low Back Pain
- ☐ Sexual Dysfunction
- ☐ Fatigue between meals
- ☐ Weakness/Injuries in Hips/Knees/Ankles

Please list any health conditions not mentioned:_____

Please list any medications you are currently taking and their purpose:_____

_____

Please list all past surgeries:_____

_____

Please list all previous accidents and falls:_____

_____

_____

How supportive is your Spouse/Family/Significant other to you seeking care? (Be specific)_____

_____

_____

Are you willing to make dietary changes and possibly take supplements necessary for your recovery?
YES NO

How has your health condition affected your job, relationships, finances, family or other activities? Please give examples:_____

_____
_____
_____
_____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

_____
_____
_____

What are you most concerned with regarding your problem?_____

_____
_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific:_____

_____
_____

What do you desire most to get from working with us?_____

_____
_____
_____

Please list anything else we should know that would help us assess your case._____

_____
_____

I attest to all of the above pages being true and complete to the best of my ability. I understand that Chiropractic care with Dr. Lawrence at Integrative Healthcare of Atlanta may or may not be appropriate for my case and that completion of this paperwork does not mean I have been accepted into care.

Signature:_____ Date:____/____/____