Patient Information Form

Name: (Last) _____ (First)_____ (MI) _____

Name you prefer to be called: _____

Patient Address for shipping: (No PO Boxes) _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-mail: _____

Birthdate: _____ Age: _____ Sex: M F

How did you hear about us? (Circle)

Sign Internet Coupon Referral Event Direct Mail TV Attorney: _____

Employment Information:

Patient Employer: _____ Occupation: _____ Phone: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

In Case of Emergency:

Name: _____(Relationship)_____ Phone: _____

Family Physician: _____ Phone: _____

Financial Policy Agreement: Thank you for selecting Atlanta Medical Institute (AMI) for your health care needs. We are pleased to be of service to you and your family. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, American Express and checks.
By signing this Financial Policy Agreement, I agree: Should this account be referred to an agency or an attorney for collection that I will be responsible for all collection costs, attorney's fees and court costs.

Signature: _____ Date: _____

If Minor: Parent/Guardian Signature: _____ Date: _____

Comments: _____
_____
_____

Massage

I understand the Massage I receive is provided for the basic purpose of relaxation and the relief of muscle tension. If I experience any pain or discomfort during the session, I will immediately inform the massage therapist so that the pressure/stroke may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical or chiropractic examination, diagnosis or treatment. Because massage should not be performed under certain medical conditions, I affirm that I have stated all of my known conditions and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical/health status.

I assume all legal responsibility for my health and well-being. I release the massage therapist from any and all present and future responsibility. I understand that the massage therapist reserves the right to terminate my session and further sessions if deemed necessary.

Patient Signature: _____ Date: _____

If Minor: Parent/Guardian Signature: _____ Date: _____

Are You Interested in Improving Your Overall Wellness?

Do you have an interest in? (Please Circle)

- **Hormone replacement therapy:** **Yes / No**
  - Do you want to feel more energized and less anxious **Yes / No**
  - Do you want to improve your sex life? **Yes / No**
- **Weight Loss:** **Yes / No**
  - How much weight would you like to lose? _____
  - Are you ready to commit to a weight loss plan? **Yes / No**
- **Nutrition:**
  - Do you take a multi-vitamin, supplements or fish oil daily? **Yes / No**
  - Are you interested in Freshly Prepared Meals? **Yes / No**
- **Stress Reduction:** **Yes / No**
  - What kind of stress bothers you the most? (Work, family, money, etc.) _____
  - On a scale of 1-10, how much does this stress interfere with you life? _____
- **Detoxification:**
  - Are you interested in cleansing toxins from your system? **Yes / No**
- **Spinal Health (Chiropractic and Massage):** **Yes / No**
  - Do you have pain in your upper or lower back? **Yes / No**
  - Rate the severity of your pain on a scale from 1-10 _____
- **Yoga and Exercise:** **Yes / No**

PATIENT CONSENT FOR USE AND DISCOLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Atlanta Medical Institute (AMI) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to AMI's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices (NPP) prior to signing this consent. AMI reserves the right to revise its NPP at any time. A revised NPP may be obtained by forwarding a written request to AMI. With my consent, AMI may:

- call my home (or other location) and leave a message on voice mail or in person in reference to any item(s) that assist the practice in carrying out TPO, such as: appointment reminders, insurance items calls pertaining to my clinical care
- mail to my home (or other location) any items that assist in carrying out TPO, such as: appointment reminders, patient statements
- email to my home (or other location) any items that assist the practice in carrying out TPO, such as:

By signing this form, I am consenting to AMI's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, AMI may decline to provide treatment to me.

I have been offered and have had the opportunity to review the HIPAA disclosure form: _____

_____
Signature of Patient

_____ Date _____
Patient Name

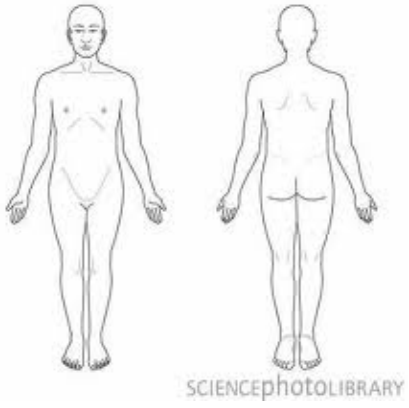
PT Name: _____

- Reason for Visit: _____
- Are you in pain/discomfort: NO YES Pain level : 1 2 3 4 5 6 7 8 9 10 Frequency: _____
- What makes it **Worse**: _____ **Better**: _____
- How long has problem existed: _____ **Preferred Pressure**: Light Medium Heavy
- Have you had Massage before: NO YES Last Massage: _____
- Is there anything you don't like about Massage: _____
- Recent Injuries: _____
- Skin Disorders: _____
- High Blood Pressure/ Diabetes: NO YES Last Reading: _____/_____
- Pregnant: NO YES Due Date: _____

Please Check all Conditions/Symptoms that apply:

	Heart Disease			Surgery			Mental Disorders
	High Cholesterol			Herpes Simplex			Insomnia
	Hospitalization			Whiplash			Hyper/Hypo-tension
	Hepatitis			Asthma			Anemia
	Carpel Tunnel			Angina			Migraines
	Sciatica			Phlebitis/Thrombosis			Fibromyalgia
	Contagious Disease			Stroke			Repetitive Strain Injuries
	Varicose Veins			Spinal/Disc Problems			Cancer
	Gout			Thyroid			Other:
	Kidney or Liver problem			Immunity Disorder (HIV)			Other:

- Activities/Hobbies/Sports: _____
- **Exercise:** None Moderate Daily Heavy **Work:** Sitting Standing Light Labor Heavy Labor
- **Smoking**: YES NO **Alcohol:** YES NO **Caffeine**: YES NO **Drugs**: YES NO
- **Medications**: _____
- **Allergies**: _____



Mark Diagram with the numbers that best describe the type of feeling you are experiencing.

1. Sharp
2. Dull
3. Throbbing
4. Numbness
5. Aching
6. Shooting
7. Burning
8. Tingling
9. Cramping
10. Tension