ATLANTA INNOVATIVE MEDICINE

Patient Health Questionnaire

8460 Holcomb Bridge Road
2nd Floor, Alpharetta, GA 30022

Patient Name:_____ Today's Date: _____

Age:_____ Sex: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married/Partnered ❒ Widowed ❒ Divorced

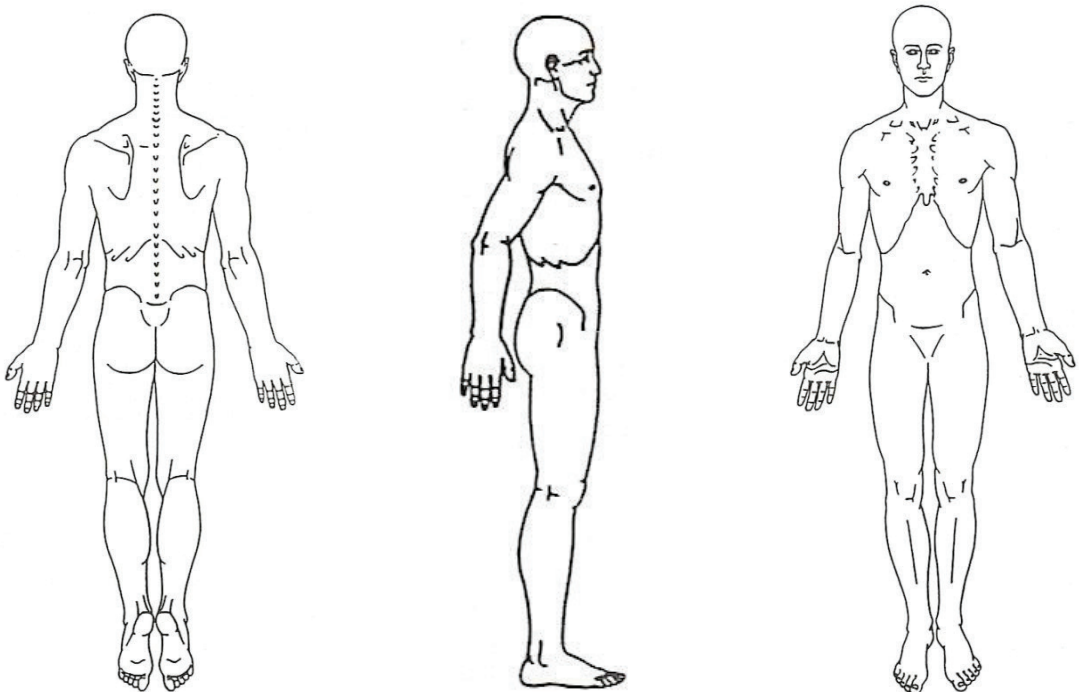
Children: ❒ Yes ❒ No How many?_____

Resides With: ❒ Alone ❒ Spouse/Partner ❒ Parents ❒ Children Other:_____

Social Security #:_____ Occupation:_____

Employer Name and Phone Number: _____

Please indicate for which body region you are seeking treatment (circle):



When did your symptoms begin? _____

How often do your symptoms occur?

❒ Occasional ❒ Intermittent ❒ Frequent ❒ Constant Other:_____

Was your pain a result of an accident or injury? ❒ Yes ❒ No

If yes, please explain_____

Using a scale of 0-10 (10 being extreme) how would you rate your pain? _____ At present _____ At best _____ At worst

What activities/positions aggravate your condition? _____

_____

What activities/positions relieve your condition? _____

_____

Have you had any treatment associated with this condition? (Ex. OTC or Rx medications, physical therapy, chiropractic care, surgical consult, injections) If so please list dates and treatments.

Date	Treatment

Have you ever been diagnosed with or had any of the following? *(Please check all that apply)*

❒ Rheumatoid arthritis
❒ Chronic headaches
❒ Bleeding disorders
❒ High cholesterol
❒ Recent unexplained weight loss
❒ Joint replacement
❒ Irregular heartbeat
❒ Metal implants/pacemaker
❒ Asthma/COPD
❒ HIV/AIDS
❒ Lupus
❒ Diabetes
❒ Head injury/concussion
❒ Blood clots
❒ Cancer
❒ Stroke/MI
❒ Osteoporosis
❒ High blood pressure
❒ Seizure disorder
❒ Other_____

Please indicate whether you are RIGHT or LEFT handed: _____

Do you smoke? ❒ Yes ❒ No How much? _____

Do you drink alcohol? ❒ Yes ❒ No How many drinks per week? _____

Do you drink caffeinated beverages? ❒ Yes ❒ No How many per day? _____

How much water do you drink per day? _____

Do you have a primary care doctor? ❒ Yes ❒ No Doctor's name and address:_____

Do you have a chiropractor? ❒ Yes ❒ No Name and Address_____

Have you been hospitalized in the past five years? ❒ Yes ❒ No

Please explain _____

Have you ever had surgery? ❒ Yes ❒ No If yes, please list type of surgery and year

Are you currently pregnant or trying to get pregnant? ❒ Yes ❒ No

Are you currently taking any medications on a daily basis? ❒ Yes ❒ No If yes, please list medication and dose (or attach copy of list)

Do you have any allergies to medicine? ❒ Yes ❒ No If yes, please list medication and reaction

Are you currently taking any supplements on a daily basis? ❒ Yes ❒ No If yes, please list

What are your goals while receiving treatment in our office and the timeframe:

I understand and agree that the health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature_____ Date_____