

Patient Information

Atlas Total Health

Name _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

E-mail _____ Future appointment reminder by: Text _____ or Voicemail _____

Age _____ Date of Birth _____ Marital Status: M S W D How many children _____

Occupation _____ Employer _____

Address _____ Work Phone _____

Name of Spouse _____ Employer _____

Occupation _____ Work Phone _____

Patient's Emergency Contact _____ Phone _____

Referred by _____ Date of Last Physical Exam _____

Have you ever suffered from:

Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Backaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arm Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Digestive Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mid Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lower Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leg Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stress	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Any symptoms other than the above _____

Other doctors seen for this condition _____

Have you been treated for any health condition by a physician in the last year Yes No

Describe _____

Primary Healthcare Physician (PCP) _____ Phone _____

Any family history of disease or illness _____

Are you pregnant Yes No

Do you smoke Yes No Do you drink alcohol Yes No Do you use drugs Yes No

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment _____

Are you insured Yes No Company _____ Phone _____

I consent to treatment as necessary or desirable to the patient first named above. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made. I further agree if this account be placed in the hands of any attorney or collection agency for collections, I will be responsible for all reasonable collection, attorney and/or court fees. I hereby assign to this office, my rights to receive payments from negligent parties or from insurance companies. I hereby authorize the release of any medical or other information to process claims for payment. I hereby authorize and direct my attorney to pay directly to Atlas Total Health such sums as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. Payments should be payable to and mailed to:

Patient's Signature _____ SS# _____ Date _____

Guardian's Signature _____ SS# _____ Date _____

Attorney's Signature _____ Date _____

ATH11

Review of Systems

Patient Name: _____

Today's Date: _____

Please check the signs and/or symptoms related to the following body systems you now have or have experienced in the past.

CONSTITUTIONAL

- Deny All
- Chills
- Drowsiness
- Fainting
- Fatigue
- Fever
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

EYES

- Deny All
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Dry Eyes
- Eye Pain
- Field Cuts
- Glaucoma
- Sensitivity to Light
- Tearing
- Wears Glasses

CARDIOVASCULAR

- Deny All
- Angina
- Chest Pain
- Claudication
- Heart Murmur
- Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Orthopnea
- Palpitations
- Shortness of Breath
- Swelling of Legs
- Varicose Veins

RESPIRATORY

- Deny All
- Asthma
- Bronchitis
- Dry Cough
- Productive Cough
- Coughing up Blood
- Difficulty Breathing
- Difficulty Sleeping
- Hemoptysis
- Pneumonia
- Sputum Production
- Wheezing

MUSCULOSKELETAL

- Deny All
- Arthritis
- Neck Pain
- Decreased Motion
- Gout
- Injuries
- Joint Pain
- Joint Stiffness
- Locking Joints
- Back Pain
- Muscle Cramps
- Muscle Pain
- Muscle Twitching
- Muscle Weakness
- Swelling

INTEGUMENTARY

- Deny All
- Breast Lumps / Pain
- Change in Nail Texture
- Change in Skin Color
- Eczema
- Hair Growth
- Hair Loss
- History of Skin Disorders
- Hives
- Itching
- Paresthesia
- Rash
- Skin Lesions

GASTROINTESTINAL

- Deny All
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

GENITOURINARY

- Deny All
- Birth Control Therapy
- Burning Urination
- Cramps
- Erectile Dysfunction
- Frequent Urination
- Hesitancy / Dribbling
- Hormone Therapy
- Irregular Menstruation
- Lack of Bladder Control
- Prostate Problems
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

ENMT

- Deny All
- Bad Breath
- Dentures
- Deviated Septum
- Difficulty Swallowing
- Discharge
- Dry Mouth
- Ear Drainage
- Ear Pain
- Frequent Sore Throats
- Head Injury
- Hearing Loss
- Hoarseness
- Loss of Smell
- Loss of Taste
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Sinus Infections
- Runny Nose
- Snoring
- Sore Throat
- Ringing in Ears
- TMJ Problems
- Ulcers

NEUROLOGICAL

- Deny All
- Change in Concentration
- Change in Memory
- Dizziness
- Headache
- Imbalance
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors

PSYCHIATRIC

- Deny All
- Agitation
- Anxiety
- Appetite Changes
- Behavioral Changes
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Homicidal Indication
- Insomnia
- Location Disorientation
- Memory Loss
- Substance Abuse
- Suicidal Indication
- Time Disorientation

ENDOCRINE

- Deny All
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

HEMATOLOGIC / LYMPHATIC

- Deny All
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusions
- Bruise Easily
- Lymph Node Swelling

ALLERGIC / IMMUNOLOGIC

- Deny All
- History of Anaphylaxis
- Itchy Eyes
- Sneezing
- Specific Food Intolerance



Privacy Practices Acknowledgement

Acknowledgement form:

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Signature: _____

Date: _____