Applied Kinesiology Center
Acupuncture Center of Atlanta
17A Lenox Pointe NE
Atlanta, GA 30324

Confidential Introductory Patient Information Todays Date_____

Name:_____SS#_____Home Phone:(___)_____Cell Phone (___)_____.

Address:_____City:_____State:_____Zip:_____

Age:_____Birthdate:_____Sex:____Marital Status: Married/Partner Name:_____ S D W

Children_____Ages:_____ Email Address:_____

Occupation:_____Employer:_____Work Phone:(___)_____

Contact in emergencies:_____Phone:(___)_____

Who may we thank for referring you? How did you hear about us?_____

What is the reason you are seeing us today?_____

How will you know when you are better?_____

When did your problem first appear?_____What relieves it?_____

Is it getting worse, better, or staying the same?_____What makes it worse?_____

Does it affect your daily living?(work, sleep, exercise, etc..) If so how?_____

What treatments have you had for this condition?_____

Are there any other symptoms you have?_____

Name of primary doctor or physician:_____Date of last physical:_____

Address:_____Results:_____

Have you ever seen a chiropractor or acupuncturist before? Which?_____

Doctor's name:_____Address:_____

List dates and types of surgeries you have had:_____

Have you had any serious injuries? If so what and when?_____

Have you had any serious illnesses in the past?_____

Please list any hospitalizations both inpatient and outpatient treatments:_____

_____

Please list any medications you currently take: prescription:_____

Over the counter? How often?_____

Have you ever taken any antibiotics? For what? How long?_____

Have you ever broken any bones?_____

Do you or have you ever played any sports? If so what?_____

In the process of getting well, what % of the responsibility do you think is your own/doctors? _____Own_____Doctors

Is there anything you are unwilling to change in order to get well?_____

What has prevented you from getting well in the past?_____

What do you feel is a reasonable time frame in which to reach satisfactory resolution of your primary complaint?_____

Please list the specific therapies, remedies and or treatments that you have tried that:

1. Have helped and continue to help._____

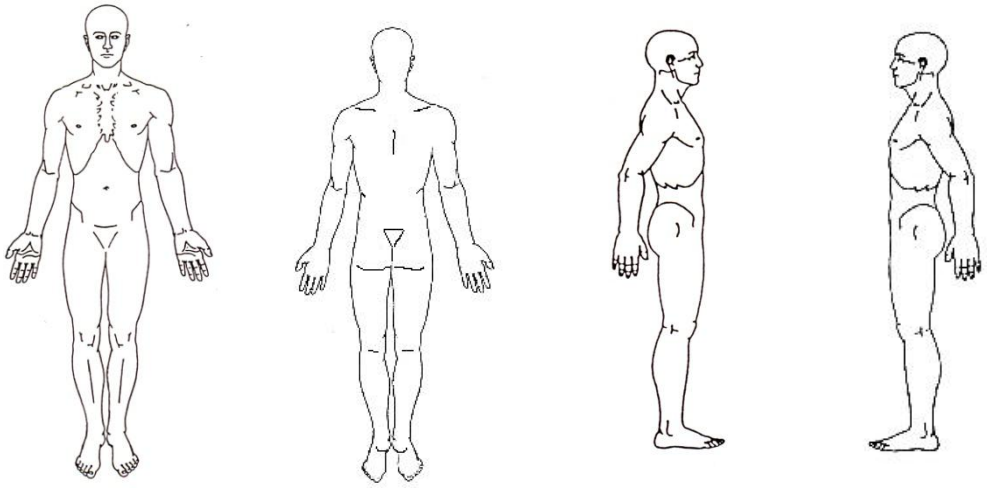
2.Have been ineffective._____

3. Helped at first but no longer do._____

4. Have made you worse._____

5. Have been suggested or prescribed that you do not follow._____

Please mark below all problem areas and describe (ie. P – Pain, N – numbness, I - Irritation, muscle strain etc.)



Comments

List any additional information which would help us better understand your condition_____

_____

I understand that I am personally responsible for payment, both for services when rendered and for missed appointments if I fail to give 24 hours advance notice of cancellation. Furthermore, I understand and agree that my health and accident insurance policies are an arrangement between my insurance carrier and myself. Any insurance proceeds inadvertently paid directly to the Applied Kinesiology Center/Acupuncture Center of Atlanta will be credited to my account and any balance refunded to me. In the event the Applied Kinesiology bills my insurance for me I will be responsible for any unpaid balances. I hereby authorize the release of any information related to my diagnosis and treatment to any insurance agency, attorney, attending physician or employer in order to properly administer the dispensation of my case. I acknowledge that Medicare will not cover these services. **I have read and been furnished a copy of this office's privacy practices pertaining to HIPAA compliance and have had any questions answered**.

Please print you name_____

Patient's Signature_____ Date_____