

Health Solutions

Achieving Extraordinary Health



3535 Roswell Road N.E. Suite 58
Marietta, GA 30062
Voice: (770) 565-5510 Fax: (770) 565-5213

Health Problems? ... Health Solutions!

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in improving and maintaining your health.

Patient Information

Today's date: ____/____/____

Name: _____ Email address: _____

Address: _____ City _____ State _____ Zip _____

Phone #: _____ - _____ - _____ Cell Phone #: _____ - _____ - _____ Sex M F Age _____ Birth Date: ____/____/____

Single Married Separated Divorced Who may we thank for referring you? _____

Patient employed by _____ Occupation _____ Business Phone# _____ - _____ - _____

Notify in case of emergency _____ Relation _____ Cell Phone #: _____ - _____ - _____

Do you consider yourself: Underweight Overweight Just Right

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? Yes No

Is your job associated with potentially harmful chemicals (pesticides, radioactivity, solvents)? Yes No

Do you have sugar or carbohydrate cravings? Yes No

Do you smoke? Yes No

Do you have an Irritable Bowel? Yes No

Strong Like or Dislike for any of the following flavors: (use L or D) __sour __bitter __sweet __rich/fatty __spicy __salty

How often are you having bowel movements? 1 X a day 2 or more X's a day other (specify) _____

Type of Discomfort: Bloating Belching/Gas Diarrhea Constipation Abdominal Pain Nausea
 Cramping Heartburn Other _____

Are your symptoms interfering with: Work Sleep Daily Routine Recreation

Is there anything that makes the condition worse? _____

When did symptoms begin (date) ____/____/____ Have you had similar condition in the past? Yes No

What types of therapy have you tried for this problem (s): Diet modification Fasting Vitamins/Minerals Herbs
 Homeopathy Acupuncture Conventional Drugs Other _____

The level of stress you are experiencing on a scale of 1 to 10 (10 being the highest) _____

What are your sources of stress? Job Children Relationships Other (specify) _____

How many times a week do you exercise? _____ Is your exercise program: Couch Potato Low Moderate Intense

What types of exercise do you do? Cardio Weights Other (specify) _____

What do you do to relax your body and mind on a regular basis? _____

How many meals/snacks per day to you eat? _____ How much water do you drink daily? _____

What type of water do you drink? Tap Bottled Other (specify) _____

Please list any medications (including pain killers) you are taking: _____

Please list current health problems for which you are being treated: _____

Women: Are you pregnant? Yes No If yes, how far along? _____ Due Date: _____ Nursing? Yes No

Please list all nutritional supplements you are presently taking: _____

Are you aware of any allergic/sensitivity reactions toward any food items, air-borne particles, chemicals, perfumes, ect?

Yes No If yes, please list: _____

Health Goals

Would you like to:

- | | | | | |
|---|---|--|---|---------------------------------------|
| <input type="checkbox"/> Have more energy | <input type="checkbox"/> Be less moody | <input type="checkbox"/> Improve memory | <input type="checkbox"/> Less colds & Flu | <input type="checkbox"/> Be stronger |
| <input type="checkbox"/> Be more muscular | <input type="checkbox"/> Be thinner | <input type="checkbox"/> Be pain free | <input type="checkbox"/> Rid of Allergies | <input type="checkbox"/> Sleep better |
| <input type="checkbox"/> Improve Complexion | <input type="checkbox"/> Be less depressed | <input type="checkbox"/> Feel more motivated | <input type="checkbox"/> Have more endurance | <input type="checkbox"/> Be more |
| <input type="checkbox"/> Be less indecisive | <input type="checkbox"/> Be more organized | <input type="checkbox"/> Be more organized | <input type="checkbox"/> Think more clearly | <input type="checkbox"/> focused |
| <input type="checkbox"/> Stop using laxatives | <input type="checkbox"/> Reduce risk of inherited disease | | <input type="checkbox"/> Not be dependent on over-the-counter drugs | |

Physical Assessment

Please mark any that currently apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Allergies | <input type="checkbox"/> Severe Frequent Headaches |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Dark areas around face | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Pale Complexion | <input type="checkbox"/> Water Retention | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Frequent Illness/Earaches | <input type="checkbox"/> Diabetic/Hypoglycemia |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Feeling of Weakness or Tiredness | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Elevated Blood Pressure | <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Insomnia |

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Health Solutions to help determine appropriate health services. If there is any change in my medical status, I will inform the doctor immediately. I also understand that all patient related information is kept strictly confidential by Health Solutions and released only by prior authorization of the patient or legal guardian of the patient.

I understand that I am financially responsible for all charges and will pay at the time services are rendered.

Signature _____

Date ____/____/____