INSTRUCTIONS FOR FILLING OUT AND TRANSMITTING YOUR FORM:

The following form is a "fillable" PDF file. You can type your answers on your computer, then email, fax and/or print out the form when you're finished.

If you prefer to hand-write your answers, you can print the blank form and scan/email or fax it to us.

VERY IMPORTANT INSTRUCTIONS TO USE THE "FILLABLE" FORM:

1. **SAVE the Email attachment to your desktop.** If you don't do this, you will not be able to save your entries and will lose all your work unless you can print the form before you close it.
2. Once you have saved the file to your computer, you can fill it out either partly or completely, and still be able to save your work and come back later to finish it, email it or print it out.
3. After you email or fax us your form, please call and confirm that we received it and can read it.

Phone: (770) 937-9200

Email to: PatientServices@AlternativeHealthAtlanta.com

Fax to: (888) 908-2624

AlternativeHealth Atlanta
GET YOUR LIFE BACK
Melodie M. Billiot, D.C.

New Patient Information Form

Please Print Clearly. Please complete ALL information on this form (12 PAGES). V.8.0

We must receive your completed Patient Information Form BEFORE your visit. This allows our doctors to familiarize themselves with your case and do any needed research before your visit. Therefore, you should fill out the form immediately and Email it to us, or Fax it to us at (888)908-2624. **You should also BRING a copy with you as a backup.**

PERSONAL INFORMATION

Today's Date: _____

First Name: _____ Middle Initial: ____ Last Name: _____

Mr., Mrs., Ms., Dr., Etc.: _____ Called (Nick) Name: _____

Address: _____ Apt.#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Best Number to call for appointment Reminders: _____

E-mail (for patient communication, newsletters, etc.): _____

Birth date: _____ Age: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Occupation: _____ Employer: _____

If patient is a minor, parent / guardian name(s): _____

Emergency Contact Name: _____ Phone: _____

Referred By (how did you hear about us?): _____

FINANCIAL INFORMATION

Person responsible for payment: ☐ Self ☐ Other If other: Name: _____ (We do not file insurance)

Method of Payment: ☐ Cash ☐ Check ☐ Visa / MasterCard / Discover / American Express

HEALTH HISTORY

List any major illnesses or injuries with approximate dates:

Illness or Injury Description	Aprox. Date	Complications or Comments	Full Recovery?

Office Use Only

List any surgery or operations with approximate dates:

Surgery Description	Aprox. Date	Complications or Comments	Full Recovery?

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PRESENT COMPLAINTS

List the main health complaints you have in order of their importance to you:

1. Description of your MAIN or WORST health problem: _____

First began how long ago? _____ How often does this bother you? _____

What treatments have you tried? _____

Anything that makes it better? _____

Anything that makes it worse? _____

Has this problem been getting better, worse or staying the same? _____

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2. Description of your SECOND WORST health problem: _____

First began how long ago? _____ How often does this bother you? _____

What treatments have you tried? _____

Anything that makes it better? _____

Anything that makes it worse? _____

Has this problem been getting better, worse or staying the same? _____

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Please Continue on Next Page

3. Description of your THIRD WORST health problem: _____

First began how long ago? _____ How often does this bother you? _____

What treatments have you tried? _____

Anything that makes it better? _____

Anything that makes it worse? _____

Has this problem been getting better, worse or staying the same? _____

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4. Description of your FOURTH WORST health problem: _____

First began how long ago? _____ How often does this bother you? _____

What treatments have you tried? _____

Anything that makes it better? _____

Anything that makes it worse? _____

Has this problem been getting better, worse or staying the same? _____

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5. Description of your FIFTH WORST health problem: _____

First began how long ago? _____ How often does this bother you? _____

What treatments have you tried? _____

Anything that makes it better? _____

Anything that makes it worse? _____

Has this problem been getting better, worse or staying the same? _____

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6. Please write down any other complaints or problems that you haven't listed yet:

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COMMON COMPLAINTS SURVEY: PLEASE FILL OUT COMPLETELY!

Please check all boxes below that apply in your case. If you check the box, please include details of the problem on the blank line. If you have already listed the problem above as one of your main symptoms, just write "see above" on the line.

☐Headaches?: _____

☐Fatigue / Low Energy?: _____

☐Neck stiffness or pain?: _____ ☐Shoulder pain?: _____

☐Back stiffness or pain?: _____

☐Other Pain anywhere in body?: _____

☐Trouble getting to sleep?: _____ ☐Not rested in mornings?: _____

☐Wake in the night and have trouble getting back to sleep?: _____

☐Irritability, mood swings?: _____

☐Digestive gas?: _____ ☐Bloating?: _____ ☐Heartburn?: _____

☐Reflux?: _____ ☐Diarrhea?: _____ ☐Constipation?: _____

☐Allergies / Sinus Problems?: _____

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DRUGS, MEDICATIONS, SUPPLEMENTS

Current medications / drugs being taken, including "over the counter" medications: (use a separate sheet if needed):

Drug Name	Taken for What Symptom or Condition?	Taken How Often?	Aprox. Start Date (or years ago)	Are you experiencing any Side Effects?

ANTIBIOTICS: # antibiotic runs past year: _____ Avg. # runs per year for past 5 years: _____ Past antibiotics? _____

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Please list any dietary supplements that you take regularly:

Supplement Name or Description	Taken For:	Started How Long Ago?	Results or Effects you've noticed?

To your knowledge, have you ever had long-term exposure to chemicals, pesticides, herbicides, radiation, solvents or heavy metals? ☐No ☐Yes

If yes, explain: _____

Do you have, or have you ever had, "silver" fillings in your teeth? ☐No ☐Yes Root canal(s)? ☐No ☐Yes

Have you had tooth extractions? ☐No ☐Yes Are you currently having any trouble with your teeth? ☐No ☐Yes If YES, please explain:

_____

_____

Please Continue on Next Page

WOMEN ONLY: MENSTRUAL HISTORY

Date of Last Menstrual Period: _____ Age at first onset: _____

Are your periods regular? ☐No ☐Yes If not, explain: _____

Do you experience cramping? ☐No ☐Slight ☐Moderate ☐Severe Do you have any PMS symptoms? ☐No ☐Yes

If so, what? ☐Bloating ☐Cravings ☐Back pain ☐Irritable ☐Moody ☐Other: _____

Are you currently pregnant? ☐No ☐Yes

Birth Control Pill Information: Have you ever used Hormonal-type Birth Control? (Pills, Patch, Injection, Implant, Hormone IUD) ☐No ☐Yes

Are you currently on Hormonal-type Birth Control? ☐No ☐Yes Total years on Hormonal-type Birth Control? _____. Stopped ____ years ago.

I was originally on Birth Control Pills for: ☐Birth Control ☐PMS / Irregular Cycle / Other problem (Fibroids, Endometriosis, etc.).

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FAMILY HISTORY

Marital Status: ☐S ☐M ☐W Name of spouse: _____ Number of Children, if any: _____

Describe health of spouse: _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M / F	_____
_____	____	M / F	_____
_____	____	M / F	_____
_____	____	M / F	_____

Any family history of serious illnesses? Cancer ☐Diabetes ☐Heart ☐Other: _____

Any household pets or other animals you or family members are in close contact with: _____

Do pets have health conditions of any kind? _____

DOCTOR OR PHYSICIAN

Are you currently under the care of a physician or other health care professionals? ☐No ☐Yes

If Yes, Doctor's name: _____ Specialty: _____ Date of last visit: _____

GENERAL HEALTH QUESTIONS

What is your present weight? _____ What is your ideal weight? _____ Are you currently: ☐Gaining Weight ☐Losing Weight

What time(s) of day are you most tired? _____

Do you get: ☐Depression ☐Worry ☐Lack of concentration ☐Memory Problems ☐Anxiety ☐Panic Attacks ☐Other: _____

More Information on above problems: _____

Number of bowel movements: ☐More than 1/day ☐1 /day ☐Every 2 days ☐3 /week ☐2 /week ☐1 /week ☐Other: _____

List any allergies or foods / substances you are sensitive to: _____

STRESS or MAJOR LIFE CHANGES: (example: divorce, losses, trauma, major problems in life, etc.): _____

Please Continue on Next Page

DIET AND LIFESTYLE:

☐Coffee (☐sugar ☐milk ☐non-dairy creamer) _____ Cups per: ☐Day ☐Week ☐Month

☐Tea (☐sweet ☐unsweet) _____ Glasses per: ☐Day ☐Week ☐Month

☐Alcohol What kinds and how often? _____

Have you consumed large amounts of alcohol, or had frequent drinks over a period of a year or more (☐currently ☐past)? _____

☐Chocolate or candy _____ Times per: ☐Day ☐Week ☐Month ☐Diet Soda _____ Glasses per: ☐Day ☐Week ☐Month

☐Regular Soda _____ Glasses per: ☐Day ☐Week ☐Month ☐Artificial sweeteners _____ Times per: ☐Day ☐Week ☐Month

☐Laxatives _____ Times per: ☐Day ☐Week ☐Month ☐Fast Food _____ Times per: ☐Day ☐Week ☐Month

☐Milk / Cream _____ Times per: ☐Day ☐Week ☐Month (include cream in coffee, milk on cereal, etc.)

☐Cigarettes How many and how often? _____

☐Past Cigarettes How many and how often? _____ Quit how long ago? _____

☐Recreational Drugs What drugs and how often? _____

☐Past Recreational Drugs If any heavy use of drugs in past, what drugs and how long ago? _____

Hobbies / activities you enjoy _____

Hobbies / activities that are limited or prevented by your current health condition? _____

_____

Past and Current Diet Information:

Give some examples of *foods you were raised on as a child*:

Breakfast: _____

Lunch: _____

Snacks: _____

Dinner: _____

Liquids: _____

How many meals do you usually eat per day? _____ If less than 3, which do you skip most often? ☐Breakfast ☐Lunch ☐Dinner

Do you have any diet restrictions? ☐Yes ☐No If yes, what are they? _____

Do you eat breakfast? ☐Yes ☐No When? _____

Example of breakfast foods eaten: _____

Do you eat lunch? ☐Yes ☐No When? _____

Example of lunch foods eaten: _____

Do you eat dinner? ☐Yes ☐No When? _____

Example of dinner foods eaten: _____

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Please Continue on Next Page

Do you snack? ☐Yes ☐No Check all that apply:

☐During the day / between meals ☐Give example of foods eaten: _____

☐After dinner ☐Give example of foods eaten: _____

☐Before bed ☐Give example of foods eaten: _____

Check all that apply:

☐Digestive issues ☐Low energy ☐Tired before or after meals

☐Can't get full ☐Salt/Sugar Cravings ☐Sugar cravings after meals

☐Uncontrollable cravings

What are your food challenges? Check all that apply:

☐I hate to cook ☐My family won't eat healthy food ☐My schedule is crazy

☐I don't know how to cook ☐Healthy food is too expensive ☐I don't like vegetables

☐Healthy food doesn't taste good ☐Real food takes too long to prepare ☐I'm a vegetarian – how do I get protein?

☐I'm not the cook in the house ☐I hate food shopping ☐I don't know how to meal plan

☐I don't know how to follow a recipe ☐I'm never home/ eat out all the time ☐Other? _____

_____

Are you: ☐Vegetarian ☐Vegan If YES, why? ☐Philosophical or Religious ☐Health ☐Personal Preference

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Please Continue on Next Page

SYMPTOM CHECKLIST

Please check off all items you have trouble with.

Check the box that describes how severe the problem is, or how often you have this problem:

NO or RARELY: ..... leave all boxes blank.
MILD or MINOR problem: ..... check box 1.
MODERATE problem: ..... check box 2
MAJOR or SEVERE problem: ..... check box 3

Thyroid Symptoms

1☐2☐3☐: Stubborn Weight
1☐2☐3☐: Fatigue
1☐2☐3☐: Intolerance to cold
1☐2☐3☐: Cold hands or feet or low body temperature
1☐2☐3☐: Dry or itchy skin
1☐2☐3☐: Sluggish elimination or constipation
1☐2☐3☐: Mental sluggishness or lethargy
1☐2☐3☐: Anxiety
1☐2☐3☐: Depression
1☐2☐3☐: Nervousness
1☐2☐3☐: Flabby skin underneath arm and neck
1☐2☐3☐: Heart palpitations
1☐2☐3☐: Hair loss
1☐2☐3☐: Lack of interest in life
1☐2☐3☐: High cholesterol
1☐2☐3☐: Ridged nails (vertical up and down) or brittle nails
1☐2☐3☐: Pain the in the wrist (carpal tunnel syndrome)
1☐2☐3☐: Cravings for sweets
1☐2☐3☐: Insomnia

Adrenal/Heart/BloodPressure Symptoms

1☐2☐3☐: Out of breath when walking up stairs
1☐2☐3☐: Dizziness
1☐2☐3☐: Excessive facial hair - female
1☐2☐3☐: Perspiring after getting out of shower
1☐2☐3☐: Fatigue during the day
1☐2☐3☐: Difficulty getting out of bed in morning
1☐2☐3☐: Waking up in the middle of the night
1☐2☐3☐: Difficulty falling to sleep
1☐2☐3☐: Afternoon headaches
1☐2☐3☐: Arthritis or stiff and painful joints
1☐2☐3☐: Twitch under eye lid
1☐2☐3☐: Heel spurs
1☐2☐3☐: Low back weakness or pain
1☐2☐3☐: Itchiness or hives
1☐2☐3☐: Nervousness
1☐2☐3☐: Fluid retention
1☐2☐3☐: Dehydrated despite amount of fluid consumed
1☐2☐3☐: Swollen ankles
1☐2☐3☐: Allergies
1☐2☐3☐: Asthma
1☐2☐3☐: Craving salt (chips, pretzels)
1☐2☐3☐: Enlarged abdomen
1☐2☐3☐: Enlarged bump in upper back/lower neck
1☐2☐3☐: Hands and feet go to sleep easily
1☐2☐3☐: Chest pain
1☐2☐3☐: Aware of breathing heavily
1☐2☐3☐: Muscle cramps, worse during exercise
1☐2☐3☐: Dull pain in chest or radiating in left arm
1☐2☐3☐: Nose bleeds frequently
1☐2☐3☐: Ringing in the ears

Please Continue on Next Page

Check the box that describes how severe the problem is, or how often you have this problem:
NO or RARELY: ..... leave all boxes blank.
MILD or MINOR problem: ..... check box 1.
MODERATE problem: ..... check box 2
MAJOR or SEVERE problem: ..... check box 3

Digestion/Arthritis Symptoms

1☐2☐3☐: Fatigue
1☐2☐3☐: Difficulty sleeping through the night
1☐2☐3☐: Early morning insomnia
1☐2☐3☐: Bad breath
1☐2☐3☐: High blood pressure
1☐2☐3☐: High cholesterol
1☐2☐3☐: Blood sugar problems
1☐2☐3☐: Stomach bloats when eating wheat or sugar
1☐2☐3☐: Skin problems
1☐2☐3☐: Burning feet
1☐2☐3☐: Blurred vision
1☐2☐3☐: Itchy skin and feet
1☐2☐3☐: Anxiety
1☐2☐3☐: Bowel movement light colored
1☐2☐3☐: Pain between shoulder blades
1☐2☐3☐: Sneezing attacks
1☐2☐3☐: Nightmare-type dreams
1☐2☐3☐: Eating protein causes gas
1☐2☐3☐: Coated tongue (white film)
1☐2☐3☐: Indigestion, acid reflux
1☐2☐3☐: Irritable bowel problems
1☐2☐3☐: Difficulty getting out of bed in the morning
1☐2☐3☐: History of birth control pills
1☐2☐3☐: History of antibiotics
1☐2☐3☐: Toe nail fungus
1☐2☐3☐: Headaches or Migraines
1☐2☐3☐: History of Hormone Replacement Therapy
1☐2☐3☐: Fibromyalgia (many tender spots in muscles)
1☐2☐3☐: Redness in eyes
1☐2☐3☐: Painful joints
1☐2☐3☐: Low back pain
1☐2☐3☐: Lower neck stiffness
1☐2☐3☐: Right shoulder pain or tightness
1☐2☐3☐: Bloating after eating in abdomen
1☐2☐3☐: Belching/burping after eating
1☐2☐3☐: Full sensation under right rib cage
1☐2☐3☐: Yellowish color in eye whites
1☐2☐3☐: Heartburn
1☐2☐3☐: Constipation
1☐2☐3☐: Itchy private parts
1☐2☐3☐: Yeast or candida

Menopause Symptoms (female only)

1☐2☐3☐: Hot flashes
1☐2☐3☐: Night Sweats
1☐2☐3☐: Vaginal Dryness
1☐2☐3☐: Leaky bladder
1☐2☐3☐: Frequent urination at night
1☐2☐3☐: Fibroids
1☐2☐3☐: Depression
1☐2☐3☐: Endometriosis
1☐2☐3☐: Bone loss/osteoporosis
1☐2☐3☐: History of being on Hormone Replacement Therapy
1☐2☐3☐: History of taking birth control pills

Menstrual Symptoms (female only)

1☐2☐3☐: Infertile (difficulty getting pregnant)
1☐2☐3☐: PMS
1☐2☐3☐: Irregular periods
1☐2☐3☐: Depression during menstruation
1☐2☐3☐: Ovarian cysts
1☐2☐3☐: Bloating and cramping during menstruation
1☐2☐3☐: Weight gain during menstruation
1☐2☐3☐: Weight gain during ovulation
1☐2☐3☐: Difficulty losing weight after pregnancy
1☐2☐3☐: Heavy bleeding during menstruation
1☐2☐3☐: Pain in the low back pelvic area
1☐2☐3☐: Pain in the front hip area
1☐2☐3☐: Acne during menstruation
1☐2☐3☐: Knee pain
1☐2☐3☐: Fibrocystic breasts
1☐2☐3☐: Enlarged swollen breasts during menstruation
1☐2☐3☐: Bladder infections (recurrent)

Please Continue on Next Page

Check the box that describes how severe the problem is, or how often you have this problem:
NO or RARELY: .....leave all boxes blank.
MILD or MINOR problem: .....check box 1.
MODERATE problem: .....check box 2
MAJOR or SEVERE problem: .....check box 3

Blood Sugar Symptoms

1☐2☐3☐: History of diabetes in family
1☐2☐3☐: Cravings for sweets, refined carbohydrates
1☐2☐3☐: Tired in the afternoon
1☐2☐3☐: Difficulty getting to sleep at night
1☐2☐3☐: Awake after a few hours of sleep
1☐2☐3☐: Waking early morning and can't get back to bed
1☐2☐3☐: Boils
1☐2☐3☐: Acne
1☐2☐3☐: Lack of energy
1☐2☐3☐: Depression
1☐2☐3☐: Anxiety
1☐2☐3☐: History of eating lots of sugar and refined carbs
1☐2☐3☐: Slow healing
1☐2☐3☐: Numbness or tingling in finger tips or toes
1☐2☐3☐: Eye sight getting worse
1☐2☐3☐: Excessive thirst
1☐2☐3☐: Gets irritable or shaky when hungry
1☐2☐3☐: Eating improves fatigue
1☐2☐3☐: Lightheaded if doesn't eat
1☐2☐3☐: Afternoon headaches
1☐2☐3☐: Fatigue 1-2 hours after eating sugar or refined carbs

Prostate Symptoms (male only)

1☐2☐3☐: Urination difficulty or dribbling
1☐2☐3☐: Night urination frequency
1☐2☐3☐: Pain on inside of heels or legs
1☐2☐3☐: Lack of vigor and vitality
1☐2☐3☐: Legs nervous at night
1☐2☐3☐: Diminished sex drive
1☐2☐3☐: Impotency
1☐2☐3☐: Infertile

Stubborn Weight Symptoms

1☐2☐3☐: Cravings for junk food
1☐2☐3☐: Drinks wine in evenings
1☐2☐3☐: Craves refined carbohydrates
1☐2☐3☐: Frustrating stubborn weight
1☐2☐3☐: History of low-calorie diets
1☐2☐3☐: History of up and down weight
1☐2☐3☐: Fluid retention
1☐2☐3☐: History of birth control pills
1☐2☐3☐: History of Hormones Replacement Therapy
1☐2☐3☐: High protein diets don't work
1☐2☐3☐: Poor willpower
1☐2☐3☐: Can't lose weight despite exercise
1☐2☐3☐: History of blood sugar problems
1☐2☐3☐: History of menstrual problems

Please finish this form on the next page

VERY IMPORTANT QUESTION:
At the clinic, we view our most important responsibility as "Delivering what the patient wants." The statements below help us to understand what you do want so we can schedule the correct type of visit for your specific needs.

Please consider carefully and check the ONE statement that BEST describes your situation. Then, please write any other information you feel we should know in the space below. Thank you!

Considering your history and current health problems, would you say:
Please check only ONE

❑ **1. I am committed to regaining my health!** I want to do whatever is needed to become healthy and improve my quality of life. I am committed to finding the cause of why I am having these health problems no matter what—that is why I am here. **I am willing to change my diet, my lifestyle and work out the finances and time necessary to achieve my health goals as quickly as I possibly can**.

IF YOU CHECKED THE BOX ABOVE, PLEASE CHECK SELECTION BELOW THAT BEST DESCRIBES YOU:

❑ A. *I want to move ahead as rapidly as is possible to achieve the fastest and best results with my health. I will allocate the time and financial resources to do this. Please let me know how to regain my maximum health in the least amount of time possible.*

❑ B. *I will have to direct my resources more carefully to do a healthcare program. I want to make good progress, but I need to move forward a little more conservatively towards my health goals. I am willing to take a little more time to obtain a higher level of health, so I can reduce the time and financial commitment required.*

❑ C. *I have very limited resources (unemployed, fixed income, student). I still want to get to the root of my health problems and resolve the causes of my ill health. I need to work very conservatively and over a much longer period of time to obtain a higher level of health. I am ready to make the financial and time commitments that are possible for me, so I can to start on my path to wellness.*

❑ **2. I feel I am in good health overall**. I am very interested in preventing ill health and I want to put time and resources towards a preventive program to improve myself and to be as healthy as I can be.

❑ **3. I want a quick fix** and don't see a need to get to the bottom of why I have a health problem. I just want the symptom gone quickly. I do not want to make changes in my lifestyle or diet. I do not want to commit time or my resources to the effort of finding causes for my health problems.

❑ **4. I feel like I do not have any major health issues** or that they are being effectively managed by medication. I do not feel my health issues are significant enough for me to spend time or resources in resolving them at this time.

❑ **5. I am really here because** my wife (husband, mother, sister) made me come.

Additional information regarding the statements above you think we may need to know:

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END OF FORM… THANK YOU!