

## **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](mailto:PatientServices@AlternativeHealthAtlanta.com)

Fax to: (888) 908-2624



**Alternative Health**  
*Atlanta*  
 HOLISTIC WHOLE HEALTH SOLUTION  
 Melodie M. Billiot, D.C.

## Health Information Form

**Please Print Clearly. Please complete ALL information on this form**

**Today's Date:** \_\_\_\_\_

**PERSONAL INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

Address: \_\_\_\_\_ Apt.#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Best E-mail Address: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

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

**HEALTH HISTORY**

List any **major illnesses or injuries** with approximate dates:

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

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List any **surgery or operations** with approximate dates:

<b>Surgery Description</b>	<b>Aprox. Date</b>	<b>Complications or Comments</b>	<b>Full Recovery?</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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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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**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?
_____	_____	<input type="checkbox"/> M / <input type="checkbox"/> F	_____
_____	_____	M / F	_____
_____	_____	<input type="checkbox"/> M / <input type="checkbox"/> F	_____
_____	_____	<input type="checkbox"/> M / <input type="checkbox"/> F	_____

Any family history of serious illnesses? Cancer Diabetes Heart Other: \_\_\_\_\_

**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.): \_\_\_\_\_

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

***Adrenal/Heart/BloodPressure Symptoms***

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

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***

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

***Menopause Symptoms (female only)***

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

***Menstrual Symptoms (female only)***

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