

Atlanta Integrative Medicine

PERSONAL INFORMATION

TODAY'S DATE ____/____/____

NAME: LAST _____ FIRST _____ MIDDLE INITIAL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ - _____ CELL (_____) _____ - _____

WORK (_____) _____ - _____ EXT. _____

DATE OF BIRTH ____/____/____ SEX F M SOCIAL SECURITY # ____/____/____

PRIMARY CARE DOCTOR _____ REFERRING PHYSICIAN _____

MARITAL STATUS: SINGLE DIVORCED LEGALLY SEPARATED PARTNER
 MARRIED (SPOUSE NAME _____) WIDOWED UNKNOWN

EMPLOYER NAME _____ ADDRESS _____

EMPLOYMENT STATUS: FULL TIME NOT EMPLOYED RETIRED
 PART TIME SELF EMPLOYED ACTIVE MILITARY

STUDENT STATUS: FULL TIME PART TIME

RESPONSIBLE PARTY: SELF GUARANTOR RELATIONSHIP _____

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ DOB ____/____/____

EMERGENCY CONTACT:

NAME LAST _____ FIRST _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

THEIR HOME PHONE (_____) _____ - _____ THEIR WORK PHONE (_____) _____ - _____ EXT. _____

ADDITIONAL INFO

EMAIL ADDRESS _____ (will not be shared)

AUTHORIZATION TO RELEASE INFORMATION TO: NAME _____ RELATIONSHIP _____

PHONE (_____) _____ - _____

PHARMACY: NAME _____ LOCATION _____

PHONE (_____) _____ - _____ FAX (_____) _____ - _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I authorize *Atlanta Integrative Medicine* and my insurance company to release any information required to process my claims.

Patient or Guardian Signature: _____ Date: _____

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What are your most important health concerns? _____

How did you hear about our clinic? _____

Personal History

Please list all previous diagnoses for any medical conditions:

What hospitalizations or surgeries have you had? _____

What diagnostic imaging studies have you had? X-rays CT scan PET scan MRI Endoscopy
 Colonoscopy Sigmoidoscopy Bone density scan Mammogram EKG/ECG EEG

Were there any significant findings?

Please list any **prescription medications**, over-the-counter medications, vitamins, or other supplements you are taking:

Are you aware of any **allergies** to food, drugs, or other environmental allergens (cats, mold, and dust)? If yes, please list and explain:

Childhood Illnesses

Please circle whether you have/had any of the following conditions as a child/adolescent:

Diphtheria	Mumps	Polio	Rubella
German measles	Rheumatic fever	Pertussis	Chronic Ear or Throat
Measles	Scarlet fever	Chicken Pox	infections
Other _____			

Past Immunizations

Please circle any of the following immunizations you have had. If unsure, please write a question mark beside the immunization.

Diphtheria	Polio	Hepatitis A/ B
Measles/Mumps/Rubella (MMR)	Tetanus	HiB
Pertussis	Varicella (Chicken Pox)	Influenza; annually? Yes / No
Other(s) _____		

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Family History

Do you have a family history of any of the following (please circle)?

Anemia	Diabetes	Goiter	Kidney disease
Arthritis	Epilepsy	Hay fever/hives	Liver disease
Asthma	Gall bladder disease	Heart disease	Mental illness
Cancer	Glaucoma	Heart murmur	Stroke
Cataracts	Gluten Sensitivity	High blood pressure	Tuberculosis

Is your father still living? Yes; his age ____ No; age at time of death ____ Cause of death _____
 Is your mother still living? Yes; her age ____ No; age at time of death ____ Cause of death _____

Review of Systems

Please circle. Y= Yes, present condition P=Problem of the past N=No, never had the condition.

Head

Headaches	Y P N	Migraine headaches	Y P N
Head injury	Y P N	Jaw/TMJ problems	Y P N

Ear

Ringings	Y P N	Dizziness\	Y P N	Frequent wax build up	Y P N
Earaches	Y P N	Impaired hearing	Y P N	Itchy or moist ears	Y P N

Eyes

Blurred vision	Y P N	Cataracts	Y P N	Glasses/contacts	Y P N
Eye pain/strain	Y P N	Glaucoma	Y P N	Tearing/dryness	Y P N
Spots in eyes	Y P N	Color blind	Y P N	Double vision	Y P N

Nose/Sinuses

Stuffiness	Y P N	Loss of smell	Y P N	Sinus problems	Y P N
Hayfever	Y P N	Nose bleeds	Y P N	Frequent discharge	Y P N

Mouth/Throat

Hoarseness	Y P N	Gum problems	Y P N	Freq. sore throat	Y P N
Jaw clicks	Y P N	Dental cavities	Y P N	Sore lips/tongue	Y P N
Dry Mouth	Y P N				

Neck

Lumps	Y P N	Swollen glands	Y P N
Goiter	Y P N	Pain or stiffness	Y P N

Skin

Rashes	Y P N	Psoriasis	Y P N	Eczema, hives	Y P N
Lumps	Y P N	Acne, boils	Y P N	Color changes	Y P N
Itching	Y P N	Loss of hair	Y P N	Night sweats	Y P N

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Respiratory

Asthma	Y P N	Wheezing	Y P N	Spitting up blood	Y P N
Cough	Y P N	Bronchitis	Y P N	Difficulty breathing	Y P N
Sputum	Y P N	Pneumonia	Y P N	Pain with breathing	Y P N
Pleurisy	Y P N	Emphysema	Y P N	Shortness of breath	Y P N
Tuberculosis	Y P N	Difficulty breathing while lying down at night	Y P N		

Cardiovascular

Angina	Y P N	Chest pain	Y P N	Blood clots	Y P N
Murmur	Y P N	Heart disease	Y P N	Rheumatic fever	Y P N
Fainting	Y P N	Ankle swelling	Y P N	Low/high blood pressure	Y P N
Anemia	Y P N	Cold hands/feet	Y P N	Thrombophlebitis	Y P N
Leg pain	Y P N	Easy bruising	Y P N	Varicose veins	Y P N

Gastrointestinal

Diarrhea	Y P N	Constipation	Y P N	Ulcers	Y P N
Black stool	Y P N	Coughing up blood	Y P N	Jaundice	Y P N
Hemorrhoids	Y P N	Gall bladder disease	Y P N	Heartburn	Y P N
Abdominal pain	Y P N	Blood in stool	Y P N	Liver disease	Y P N
How many bowel movements per day? _____ Are they generally: loose well-formed dry and hard pebble-like					

Urinary

Incontinence	Y P N	Frequent infections	Y P N	Painful urination	Y P N
Kidney stones	Y P N	Frequency at night	Y P N	Change in color / odor	Y P N

Musculoskeletal

Joint pain	Y P N	Muscle spasms	Y P N	Stiffness	Y P N
Arthritis	Y P N	Muscle pain/soreness	Y P N	Broken bones	Y P N
Sciatica	Y P N	Muscle weakness	Y P N		

Neurological

Fainting	Y P N	Paralysis	Y P N	Numbness/tingling	Y P N
Seizures	Y P N	Loss of memory	Y P N	Muscle weakness	Y P N

Emotional

Mood swings	Y P N	Nervousness	Y P N	Tension/stressed	Y P N
Anxiety	Y P N	Depression	Y P N	Loss of loved one	Y P N

Endocrine

Hypothyroid	Y P N	Excessive thirst	Y P N	Cold intolerance	Y P N
Hyperthyroid	Y P N	Excessive hunger	Y P N	Heat intolerance	Y P N

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Male Reproductive

Hernias	Y P N	Testicular masses	Y P N	Discharge or sores	Y P N
Prostate issues	Y P N	Sexual difficulty	Y P N	Testicular pain	Y P N
Premature Ejaculation	Y P N	Sexually transmitted disease/infections	Y P N	Blood in semen	Y P N

Female Reproductive

Age of first menses _____ Age of last menses (if menopausal) _____
Length of cycle _____ Duration of menses _____
Date of last annual exam _____

Painful menses	Y P N	Endometriosis	Y P N	Ovarian cysts	Y P N
Heavy flow	Y P N	Fertility issues	Y P N	Cervical dysplasia	Y P N
Breasts tender	Y P N	Venereal disease	Y P N	Bleeding between cycles	Y P N
Sexually active	Y P N	Cycles regular	Y P N	Menopausal symptoms	Y P N
Sexual difficulty	Y P N	Abnormal pap	Y P N	PMS	Y P N
Breast lump(s)	Y P N	Nipple discharge	Y P N	Do self breast exams	Y P N

Birth control Y P N If yes, what type? _____
Number of pregnancies _____ Number of live births _____
Number of miscarriages _____ Number of abortions _____

Environmental

Circle any of the following you routinely use at home: Gas heat Oil heat Electric heat Wood stove Air conditioning Electric blanket
T.V. Distilled/ Filtered/ Spring/ Well/ Deionized/ Tap water

Is your home and work environment well ventilated? _____

Is your home or work environment excessively damp or moist? _____

Has there been any known mold growth, leaks, or large spills in your living or work area? _____

Please circle any of the following you feel most bothered by: Sunshine Lack of sunshine Dampness Dryness Cold Heat Seashore
Mountains New Moon Full Moon Dust/Mold Cat or Dog hair Car fumes Poor air/ ventilation Spring Summer Fall Winter
Change in weather (specify) _____ Wind Approach of a storm Fluorescent lighting Chemicals (specify)

Other (specify) _____

Do you get outdoors daily, even in the winter? _____

How do you feel about your work? Do you enjoy it, are you satisfied and fulfilled by it, does it provide you with the necessities of life, is it just a job you feel you must put in the hours in order to make a living? _____

Have you ever lived in or near an industrial area, waste management area, known environmentally contaminated area? _____

Have you ever worked with chemicals, pesticides, solvents, plastics, resins, metals, etc? _____

Do any of your hobbies include the use of chemicals, pesticides, solvents, plastics, resins, metals, etc? _____

Is there anything else you would like us know in order to serve you better? _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have been informed that a copy of *Atlanta Integrative Medicine's* **Notice of Privacy Practices**, is posted in the waiting room area. A copy of this **Notice** will be furnished to me upon my request.

Patient Signature _____

Date ____/____/____

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, (a Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding: unique identifiers for health plans, providers, individuals, employers, healthcare transaction & code sets for transmitting data electronically, privacy regulations over disclosure and use of health information. Security regulations over protections of electronic health information

It is our policy to **not** release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself, please complete the following

I authorize *Atlanta Integrative Medicine* to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Voice Mail	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Answering Machine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cell Phone/Voice Mail	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Work Telephone	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pager	<input type="checkbox"/> YES	<input type="checkbox"/> NO

May we fax medical records for your referrals? YES NO

Please list names of people with whom we may discuss your medical care:

Spouse Name _____ YES NO

Parent Name _____ YES NO

Other Name _____ YES NO

RELEASE OF MEDICAL RECORDS/IMAGING:

I authorize release of medical and related information including alcohol, drug abuse and mental health records obtained in the course of diagnosis and treatment to the insured's insurance carrier(s), agencies and their intermediaries or carriers, if applicable, for the purpose of obtaining care, treatment or payment for services provided or to be provided. This information may be released via USPS first class mail, facsimile or certified courier, as applicable. Authorization may be withdrawn at any time by written notification.

I authorize the release of nay and all information/records/x-rays, etc. need to evaluate my condition. I further request that this and any other pertinent information be forwarded to *Atlanta Integrative Medicine*.

REQUEST FOR MEDICAL CARE: I voluntarily consent to examination, lab evaluation, treatment and the rendering of care, including treatments and performance of diagnostic procedures. I grant my consent for treatment for myself, my spouse, or my minor children/dependent as listed on this form.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

Atlanta Integrative Medicine

Notice to Patients

Winston Cardwell, ND, LAc

*Naturopathic Physician
Licensed Acupuncturist*

Dr. Cardwell maintains *current licensure* in the state of Oregon as a Naturopathic Physician, and is licensed to practice as a primary care physician in the State of Oregon. The scope of practice includes the use of conventional medical approaches such as pharmaceutical medicine, injection therapies and minor surgery, as well as the use of more natural approaches such as botanical medicine, nutritional medicine, naturopathic manipulation therapy, hydrotherapy, dietetics, and psychological counseling. Georgia currently has no such legislation and therefore does not recognize Naturopathic Physician licensure, thereby restraining Dr. Cardwell from practicing to the full extent of his training and licensure. Additionally, he is licensed in the State of Georgia as an acupuncturist and practices under these guidelines.

In the state of Georgia, a person registered to practice naturopathy or naturopathic healing under the law may counsel individuals and treat human conditions through the use of “naturally occurring substances.” The practitioner above is a licensed Doctor of Naturopathic Medicine, (ND) and under the scope of practice for Naturopathy in Georgia, is not practicing as licensed medical doctor (MD) and therefore does not practice “*the application of scientific principles to prevent, diagnose and treat physical and mental diseases, disorders, and conditions and to safeguard the life and health of any person.*”

The underlying causes of disease can be improper diet, unhealthy habits and environmental factors that cause biological imbalance. A Naturopathic Physician specializes in wellness; the teaching of natural lifestyle approaches to facilitate the body’s healing and health building potential.

I fully understand that the above named individual is not a medical doctor. This individual may counsel me on nutrition, supplements, and better health practices.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

Atlanta Integrative Medicine

Scent-Free Policy

Many of our patients have the medical diagnosis of Multiple Chemical Sensitivity (MCS) and are EXTREMELY sensitive to chemical smells of any kind, including fragrances and tobacco smoke. **Exposures to these smells can result in serious consequences for them such as seizures, asthma, nausea, vomiting, severe headaches, vertigo and many others.**

In fairness to all of our patients, IT IS OF UTMOST IMPORTANCE that you do not wear perfume, cologne, aftershave, hair spray, hand cream or lotion, or any other scented personal care products to our office. Please do not wear clothing that may have lingering odors of cologne, perfume, fabric softener, detergent or tobacco.

Our scent-free policy also applies to anyone who may be accompanying you to our clinic. **You may be asked to reschedule your appointment if you come to the office with a scent.**

We greatly appreciate your understanding and agreement to adhere to our "Scent-Free Policy".

I have read and understand the Scent Free policy of Atlanta Integrative Medicine and agree to adhere to these recommendations.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

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Financial Policy

Our goal at *Atlanta Integrative Medicine* is to make sure your health care experience is delivered with thoroughness and the utmost in quality. We want to keep your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

- 1) You are ultimately responsible for payment of services rendered from our office. Please contact your insurance company to confirm coverage and benefits. It is the responsibility of the insured to be aware of the limits of coverage by his or her insurance carrier prior to your visit. We can NEVER guarantee coverage for any service provided by our office. There are no contractual adjustments taken as this practice does not participate with any insurance carriers.
- 2) It is your responsibility to provide us with your current address, telephone number at each visit.
- 3) A 24-hour notice is required if you are unable to keep your appointment to avoid a \$75.00 charge.
- 4) A \$150.00 deposit fee is required to hold and confirm any appointment over one hour.
- 5) There is a \$35.00 fee for checks not honored by your bank.
- 6) **Winston Cardwell ND, LAc is considered a private consultant in matters of Workman's Compensation, Disability Claims or Motor Vehicle Claims and therefore does not participate in any form of billing, paperwork or litigation for any third party claims at this time.**

I understand and accept the Financial Policy listed above.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

Atlanta Integrative Medicine

Administrative Services and Fees

The Administrative services listed below are offered to our patients and are not covered by your insurance. We require at least 48 hours for smaller medical records and up to a week for larger medical records.

- 1) Disability Letter for established patients only - \$250.00
- 2) Completion of all forms including life insurance forms and other miscellaneous forms required by third parties other than insurance companies - \$50.00
- 3) Patient requested additional claims, statements, payment histories, etc. - \$15.00
- 4) Copying of medical records to third parties including attorneys, etc. - \$75.00
- 5) Copying of medical records for patients - \$35.00, oversized charts - \$75.00 *
- 6) Copying of medical records sent from our office to other physicians and insurance companies: no charge

All of these services add to the cost of caring for our patients. Still, we are committed to providing you the best possible care at the lowest possible cost. We look forward to a lasting and healthy relationship and we thank you for your understanding and cooperation.

* Note: for simple requests such as a copy of a recent Treatment Plan or a recent laboratory results, you will not be charged the above mentioned fee.

I understand the services, fees and amount of time required, as listed above and agree to pay for them, as needed.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

Atlanta Integrative Medicine

Informed Consent for Acupuncture Treatment

Consent for Acupuncture and Oriental Medicine Treatments That May Be Administered:

I hereby voluntarily consent to receive acupuncture and Oriental Medicine treatment for my present and future health condition.

The following are possible therapies that may be utilized by your provider. Before any therapy is initiated, your provider will inform you of the therapy chosen and why; you are encouraged to ask any questions you may have. You are able to defer and/or discontinue any therapy offered or administered at any time.

Acupuncture: This is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding, and will rarely leave a bruise. Other possible risks from acupuncture include dizziness and rarely, fainting. I, the patient, will report to the licensed acupuncturist (L.Ac.) any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture, and infection (these have an extremely low incidence, especially when acupuncture is administered properly).

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of herbs, I understand that I should stop the herbs and that I am responsible for informing the L.Ac. of my symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the L.Ac. of a suspected or confirmed pregnancy, or if I am a nursing mother.

Heat Treatment with a TDP Lamp: This is used to warm an area of the body with infrared heat. Every precaution is taken to prevent over warming, but the rare possibility of mild burns exist.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight burn or blister may appear due to the heat that can be involved.

Gua Sha: Is a scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising at the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Plum Blossom (or tapping): Multiple, mild needle pricks are applied in one area. Slight bleeding at the area is likely.

Electro-Acupuncture: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

Statement of Acknowledgement

By signing below, I understand that:

- The practice of acupuncture is based upon Asian medicine and is distinct and different from traditional western medicine.
- The acupuncturist is not practicing western medicine or making a medical diagnosis of my condition unless additionally licensed by the state of Georgia as a physician.
- I should consult a physician if I want to obtain a medical diagnosis.
- I have been apprised of the following:
 - The nature and purpose of the treatment
 - The risks and benefits of the treatment
- I understand the possible risks and complications involved.
- I have had the opportunity to discuss this consent form with my ND or LAc and understand that I can request more information at any time if desired.
- I consent to receiving treatment(s) that involve the above procedure(s).
- I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.
- I agree that the above consents and authorization to release information apply to the Chinese Medicine, acupuncture, and naturopathic medical services provide for two years from the date shown below.
- I HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____