First Name: _____ MI_____ Last Name_____ Date: _____

Prefer to be called: _____ Address: _____

Home Phone #: _____ City & State: _____ Zip: _____

Cell Phone / Pager #: _____ E Mail: _____ Date of Birth: _____

( ) male ( ) female S.S. #: _____ Marital Status: S M D W No. of children: ___ Spouse' Name: _____

Occupation: _____ Employer: _____ Work Phone #:_____ ext._____

Have you ever received a Chiropractic Adjustment? _____ How long ago? _____ By whom? _____

Please tell us who referred you to our office. _____

YOUR HEALTH PROFILE

The focus in our office is your health. Our goals are, first, to address the issues that brought you to our office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual; not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the changes that have occurred and ultimately may challenge your health potential.

YOUR CHILDHOOD YEARS

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Yes	No	Not Sure		COMMENTS:
____	____	_____	Was your birth very difficult? (Forceps, cesarean, breach, with drugs)	
____	____	_____	Did you have childhood illnesses?	
____	____	_____	Did you have any serious falls or injuries?	
____	____	_____	Did you play youth sports?	
____	____	_____	Did you take / use any drugs?	
____	____	_____	Any side effects?	
____	____	_____	Did you have any surgery?	
____	____	_____	Any side effects?	
____	____	_____	Was there any prolonged use of medicine such as antibiotics or an inhaler?	
____	____	_____	Were you involved in physical accidents?	
____	____	_____	Did you suffer from any other traumas (physical or emotional)?	
____	____	_____	Were you vaccinated?	
____	____	_____	Were you seeing a chiropractor regularly?	

ADULT (18 – present)

Yes	No		
____	____	Did / do you smoke?	
____	____	Did / do you drink alcohol?	
____	____	Have you had any accidents?	
____	____	Have you had any surgeries?	
____	____	Did / do you play any adult sports?	
____	____	Did / do you participate in any extreme sports?	
____	____	Did / do you take any prescriptive drugs?	
____	____	Non prescriptive drugs?	
____	____	Any side effects?	

Addressing the Issues That Brought You to Our Office

Please briefly describe the chief area of complaint and the effect is having on your life.

_____

_____

_____

If you have no symptoms or complaints, and are here for wellness services, please check here:
_____ "I wish to have Chiropractic Wellness Care" and skip to "Family Health Profile".

If you are experiencing pain, is it …

____ Sharp ____ Dull ____Comes & goes ____ Constant ____ Travels

Since the problem started, it is… ____ getting worse ____ getting better ____ about the same

When did it start? _____What makes it worse? _____ Better? _____

It interferes with: ____ Work ____ Sleep ____Walking ____ Sitting ____ Hobbies ____ Leisure ____ Other _____

Please list any other doctors seen for this problem: _____

List any medications you are taking: _____

Please mark "1" for current symptoms, "2" for recent symptoms, and "3" if you have ever experienced the following symptoms.

____ Headaches	____ Pins & Needles in legs	____ Fainting	____ Neck Pain
____ Pins and Needles in arms	____ Loss of smell	____ Back Pain	____ Loss of balance
____ Dizziness	____ Buzzing in ears	____ Ears ringing	____ Nervousness
____ Numbness in fingers	____ Numbness in toes	____ Loss of taste	____ Upset stomach
____ Fatigue	____ Depression	____ Irritability	____ Tension
____ Problems Sleeping	____ Stiff Neck	____ Cold hands	____ Cold feet
____ Diarrhea	____ Constipation	____ Fever	____ Hot flashes
____ Cold sweats	____ Lights bother eyes	____ Urination problems	____ Heartburn
____ Mood swings	____ Menstrual Pain	____ Menstrual Irregularity	____ Ulcers

On a scale of Poor, Good, or Excellent, please describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

On a scale of 1 – 10, describe your stress level (1 = none, 10 = extreme): Occupational _____ Personal _____

Is there a family history of:
Heart Disease Arthritis Cancer Diabetes Other _____

Family Health Profile

We are also interested in the health and well being of your family and loved ones. Please use the space below to share any health concerns and conditions.

Children _____
Spouse _____
Parents _____
Siblings _____
Others _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____
Signature Date

Atlanta Natural Health

4633 Buford Highway, Atlanta GA 30341
770-455-6767 drhurd@atlantanaturalhealth.com

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expressions of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
signature date

Consent to evaluate and adjust a minor / child
I, _____being the parent or legal guardian of _____have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
signature date

Pregnancy Release
This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual period: _____

_____ _____
signature date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights *concerning* those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and *agree* with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent .

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patent may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3**.** A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to *privacy,* all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

SIGNATURE DATE

Financial Agreement

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you to get the best results in the shortest amount of time. The following are the most common services we provide:

Procedure	Purpose	When Performed	Fee
CONSULTATION	Meet with the doctor, discuss your reasons for being here, and review your case history	First visit, new injuries, or new condition	No charge
EVALUATION / EXAM	Ascertain the nature and severity of your health problem. Assess and evaluate your new or current health status and determine and appropriate course of action	First visits, new conditions, exacerbations, and progress examinations	$0.—$150
DIAGNOSTIC IMAGING (X-RAYS and scans)	Visualize the location of spinal problems and confirm other exam findings.	As necessary for 1st visit, re-injuries and progress examinations	$25. -.$150.
CHIROPRACTIC ADJUSTMENTS	Reduce and remove the Vertebral Subluxation	As indicated by examination	$35. - $55.
NUTRITIONAL RESPONSE TESTING	Access any nutritional imbalances or toxins that may be contributing to or compromising your body's ability to heal and function at its optimal state	As indicated by examination and evaluation and interest of patient	$120. Initial $35 Follow Up
BEMER	Improvement of micro vascular function	Interest of patient	$15 - $20 (packages available)
NSRT / BAX	Stress reduction using Low Level Light Laser Therapy and homeopathic support.	Interest of patient	$75 (packages available)
DETOX FOOTBATH	Stimulate detoxification processes and pull toxins from the body	Interest of patient	$30 (1st only $25) (packages available)
HEALTH COACHING	Create a vision and plan for attaining the ideal expression of your authentic expression of potential.	Interest of patient	$90 (packages available)

Forms of Payment

We accept cash, personal checks, Visa, Mastercard, Discover, Tradebank, and Equitrade. Payment is expected at time of service unless other arrangements have been made. Billing is taken care of at the front desk unless other arrangements need to be made. Services may be paid for in advance.

Special Arrangements

We have never denied anyone the benefit of care due to their inability to pay our published fees. Individual contracts can be designed to help specific financial needs. The most important thing to us is that people are given what they need.

Preferred Chiropractic Doctor (PCD)

Dr. Hurd is a participating provider with a national organization that legally allows us to reduce our fees for participating members. PCD membership is available to all patients. Reduced PCD rates are only applicable when insurance reimbursement is not going to be used. Annual membership fee is only $37.00 for an individual or family. You can join here or online at www.bewell2.com. **Discounted prepayment plans are also available to PCD members**, details are provided on additional forms.

Product Returns

Unopened supplements may be returned for a full refund within 90 days of purchase. There is no refund on opened products.

I certify that all information provided is true and complete. I agree to pay the amount invoiced in full. I further agree to pay all costs of collection, including costs of a collection agency if the account is turned over to a collection agency, and including 15% attorney's fees and court costs in the event this balance is turned over to an attorney. It is agreed that this agreement will be governed under the law of the State of Georgia. The Atlanta Natural Health Clinic has the option of pursuing an action under this agreement in any court of competent jurisdiction in the State of Georgia and I consent to jurisdiction in the State of Georgia.

Signature of patient: _____ **Date:** _____