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
HOLISTIC WHOLE HEALTH SOLUTION
Melodie M. Billiot, D.C.

Health Information Form

Please Print <u>Clearly</u>. 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?

Office Use Only

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

Surgery Description	Aprox. Date	Complications or Comments	Full Recovery?

Office Use Only

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.).

Office Use Only

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: ____________

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.): ____________

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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 Questions? Call us at (770) 937-9200 © 2000 - 20018 Dr. Melodie M. Billiot, PC

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

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