# Patient Information

**How did you hear about us:** ______________________________

**Name (First, Middle, Last):**___________________________________ **Date of Birth:** ________________

**Address:**______________________________________________________

**City:**________________________**State:**____________**Zip:**_____________

**Email:**__________________________________________________ **Phone Number:** ________________

**Occupation:**___________________________________________________

**Emergency Contact:**
**Name:**__________________________ **Relationship:**________________
**Phone Number:**___________________________________

---

## Please check if the following applies to you:

- ☐ Hot flashes
- ☐ Night sweats
- ☐ Vaginal dryness
- ☐ Vaginal pain
- ☐ Weight Gain
- ☐ Insomnia
- ☐ Anxiety
- ☐ Headaches/Migraines
- ☐ Depression
- ☐ Breast tenderness
- ☐ Brain Fog
- ☐ Loss of muscle mass
- ☐ Low sexual desire
- ☐ Irritability
- ☐ lack of motivation
- ☐ Difficultly with orgasm
- ☐ Incontinence
- ☐ Low Energy
- ☐ Painful intercourse

## Please check beside other services you may be interested in:

- ☐ Women’s Hormone Therapy
- ☐ Sexual Wellness Gainswave/Femiwave
- ☐ Weight Loss / Body Contouring
- ☐ Shockwave Therapy
- ☐ Filler/Juvéderm
- ☐ P Shot
- ☐ Vampire Breast Lift
- ☐ Regenerative Medicine
- ☐ Testosterone Replacement Therapy
- ☐ Erectile Dysfunction
- ☐ Peripheral Neuropathy/Nerve Pain
- ☐ PRP Hair Restoration
- ☐ Botox
- ☐ O Shot
- ☐ Vampire Face Lift
- ☐ Allergy Testing

## Relief for:

- ☐ Knee pain
- ☐ Neck/Back pain
- ☐ Shoulder pain
- ☐ Herniated Disc/Sciatica

## **Past Medical History:** *Please check the box for any that apply*

☐ Arthritis ☐ Hepatitis A ☐ Fusion ☐ Blood Clots
☐ Fainting Attacks ☐ Hepatitis B ☐ Joint Replacement ☐ Chemical Exposure
☐ Fibromyalgia ☐ Hepatitis C ☐ Lupus ☐ Sciatica
☐ Neuropathy ☐ Gout ☐ Pinched Nerve ☐ Spider Veins
☐ Stroke/TIA ☐ Poor Circulation ☐ Varicose Veins ☐ Low Back Pain
☐ HIV ☐ Spinal Fractures ☐ Ulcers ☐ Poor Wound Healing
☐ Shingles ☐ Herniated Disc ☐ Bulging Disc ☐ Vitamin Deficiency
☐ Plantar Fasciitis ☐ Degenerative Disc ☐ Other: ________________________________________

---

*Please check the box for any that apply*

☐ Pacemaker ☐ Defibrillator ☐ Spinal Stimulator ☐ Active Cancer
☐ Blood Clots ☐ Black Outs ☐ Epilepsy ☐ Seizures
☐ Infectious Disease *(including but not limited to HIV)*

---

**Have you ever received a cancer diagnosis?** ☐ **Yes** ☐ **No**

When _________________________ Location _______________________ Type ___________________________________

**Have you ever received chemotherapy or radiation?** ☐ **Yes** ☐ **No**

When was your last treatment? __________________________________________________________________________

**Are you diabetic?** ☐ Yes ☐ No What type ____________________ What was your last A1C? ________________

---

### **Health Habits and Personal Safety**

**Exercise**: ☐ None ☐ Mild ☐ Occasional vigorous exercise ☐ Regular vigorous exercise

**Rate your quality of sleep:** 1-Worst 10-Best ______________________

Alcohol: ☐ Yes Number of drinks per week: _____________ ☐ No
Tobacco: ☐ Yes ☐ Cigarettes ☐ Cigars ☐ Chewing ☐ No

Illicit drug use: ☐ Yes Explain: ______________________________________________________

**Primary Care Doctor (PCP)** ________________________________________

**Phone Number** ________________________________________________

**List your prescribed medications and any over-the-counter medications, such as vitamins and inhalers.**

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

**Allergies**

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

**Surgeries:**

Year _____________ Surgery/Reason ________________________________________________________________________
Year _____________ Surgery/Reason ________________________________________________________________________
Year _____________ Surgery/Reason ________________________________________________________________________
Year _____________ Surgery/Reason ________________________________________________________________________

## GENERAL CONSENT FOR TREATMENT

**As a patient of Atlantic Integrative Medicine, I hereby request and authorize the providers and staff to provide me with the recommended medical, diagnostic and treatment as they deem necessary.**

**I am aware that the practice of medicine is not an exact science and I acknowledge that NO guarantees have been made to me as the result of any medical examinations or treatments. I am also aware that in the practice of medicine other unexpected risks or complications not discussed may occur. I also understand that during any proposed procedure or treatment, unforeseen conditions may be revealed requiring the performance of additional procedures. If additional procedures are required in non-emergency circumstances, I will be provided with additional education so I may make an informed decision. Additional consent forms may be provided to me.**

**I understand that all information pertaining to my care will remail a confidential part of my medical record.**

___________________________________________________________ ____________________________________

**Patient Signature** **Date**