Basic Health History Form

(All personal Information is considered Private and Confidential)

*Please print **legibly** and double-check that your **full mailing address**, email, phone number & all other information is correct! Thank you.*

Date: _____/_____/_____ (MM / DD / YYYY) **How did you hear about us?_____**

Name: _____ (LAST FIRST M.I.)

Address: _____ City: _____ State: ____ Zip: _____

Home # (____) _____ Cell # (____) _____ Occupation: _____

Email Address: _____

Would you like to be emailed about future specials & promotions? ☐ **Yes**, please ☐ **No**, thank you

Emergency Contact Information:_____ _____ (Name / Relation / Phone #)

Personal Health History

Height:____ ____ (FT IN) **Weight:_____** (Lbs) **Birth Date: _____/_____/_____** (MM / DD / YYYY) **Age: ____ Sex: M F**

Are you currently or have recently been under the care of a Physician? Yes☐ No☐

Please Explain: _____

Primary Care Physician's information: _____ (Dr. Name / City/State / Phone #)

Have you been admitted to a hospital, had any surgical procedures, major illness, broken bones or accidents in the past 2 years? Yes☐ No☐ If Yes, please explain:_____

_____

Are you currently taking any medications? Yes☐ No☐ If Yes, which ones: _____

_____

Do you take any daily supplements (vitamins, minerals, herbs, etc.)? Yes☐ No☐

If Yes, please indicate what supplements you take and how often: _____

_____

General Habits

How often do you typically exercise? _____ Typical hours of sleep per night? _____

How much water do you typically drink daily? _____ Typical # of bowel movements per week? ____

What types of foods do you typically eat? _____

How often do you typically use any of the following? (# of times per week)

Alcohol _____ Tea _____ (cups) Coffee _____ (cups) Tobacco _____

Health Information Privacy Notice

Authorization for Use and Disclosure of Protected Health Information

In compliance with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule)**, Atlanta Colonic & Massage is dedicated to protecting the privacy and security of each and every clients Personal Health Information. Your personal health information is protected by law and it is your right to receive quality care without concern that your information will be shared or disclosed to others. The employees and therapists of Atlanta Colonic & Massage and all affiliated Independent Contractors have signed confidentiality agreements to follow the policies and procedures of our facility and all applicable Federal & State laws, regarding protection of your personal health information.

By signing, I authorize **Atlanta Colonic & Massage** to use and/or disclose certain Protected Health Information (**PHI**) about me to employees, therapists or affiliated Independent Contractors providing services to you, as applicable for therapy(s) received. Your personal identifiable health information will never be given away, sold or disclosed to any outside agency, company or organization, nor will it be released for any purpose other than collection of account payment, when required by state or federal laws, or as anonymously compiled for research purposes, without your written authorization. Results of therapies may be collectively compiled, after removal of personally identifying information, for research purposes.

You have the right to examine and obtain a copy of your health records, to request corrections and request restrictions on uses and disclosures of your health information.

You do not have to sign this authorization in order to receive therapy. In fact, you have the right to refuse to sign this authorization. When your information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization in writing except to the extent that the facility has already acted in reliance upon this authorization.

Any changes to this PHI Authorization by the client must be provided in writing.

Printed Name: _____

Signature: _____ Date: _____

Optional:

List any persons you wish to authorize for release of your personal health information or information regarding your account. (Including a spouse or other family member)*

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

*If no one is listed, we can only discuss your personal health information or account information with you.