Dr. Paul A. Dabney, N.M.D., M.P.H., M.Ed., Naturopathic and Integrative Medicine Consultant

Advance Medical & Chiropractic
6035 Preachtree Rd, Suite C209
Doraville, GA 30030
Office (470) 799-2384

Patient Information:

Name: ______________________________ Date: __________

Street Address: ______________________ City: __________ State: _________ Zip: _________

Home Phone: __________ Work Phone: __________ Cell #: __________ email: ______________

Employer: ______________________________ Family Doctor: ____________________

Birthdate: ___________ Age: ______ Height: _______ Weight: _______ Male___ Female_____

Single_____ Partnered _____ Married _____ Divorced______ Widowed__________

Personal Health Assessment

Reproductive Health (Female Only)

Yes No

--- ---- Do you have irregular cycles during menstruation?
---- ---- Do you have excessive bleeding during menstruation?
---- ---- Do your breasts get extremely sore during menstruation?
---- ---- Have you ever had an abnormal Pap exam? If yes, when? ___________
What was done about the abnormal test ____________________
---- ---- When was your last Pap test done? --
---- ---- Have you ever had ovarian cysts?
---- ---- Have you ever had fibroid cysts?
---- ---- Have you ever had endometriosis?
---- ---- Have you had difficulty conceiving children?
---- ---- Have you had a D & C?
--- ---- Have you had a miscarriage?
---- ---- Have you had a hysterectomy? When? ___________ Partial _____ Complete________
---- ---- Do you have fibromyalgia?

---- ---- Do you have low sex drive or excessive sex drive? If yes, which one Low or High

Reproductive Health (Male Only)

Yes No

---- ---- Do you have to urinate often? If yes, how often in day?________________

---- ---- Do you have prostate cancer? PSA count ________________

When was your last prostate exam?________________

What were the prostate exam findings?________________

---- ---- Do you have an enlarged testicle?

---- ---- Do you have a low sex drive?

---- ---- Do you have an excessive sex drive?

---- ---- Do you have erection problems?

---- ---- Do you have premature ejaculation?

List any other complications or problems not listed above that you are experiencing.

____

Endocrine System (Adrenal "Medulla" Glands)

Yes No

---- ---- Do you have M. S., Parkinson, or Palsy? If yes, please circle which one. MS Parkinson Palsy

---- ---- Do you feel overly anxious or have anxiety attacks?

---- ---- Do you feel excessive shyness, or feel inferior to others?

---- ---- Is the systolic (top) number of your blood pressure reading low (below 118)?

---- ---- Do you have tremors or nervous legs?

---- ---- Do you have tinnitus (ringing in your ears)?

---- ---- Do you have shortness of breath or is it hard to take a deep breath.

---- ---- Do you have or had heart arrhythmias?

---- ---- Do you have a hard time sleeping?

---- ---- Do you have Chronic Fatigue Syndrome?

---- ---- Do you get tired easily?

---- ---- Have you ever been diagnosed with Addison's Disease?

---- ---- Have you ever been diagnosed with Congenital Adrenal Hyperplasis?

Endocrine System (Adrenal "Cortex" Glands)

Yes	No	
----	----	Do you have elevated blood cholesterol levels?
----	----	Do you have lower back weakness?
----	----	Do you have or have you had sciatica?
----	----	Do you have arthritis or bursitis? If yes, circle which one. Arthritis Bursitis
----	----	Do you have any inflammatory conditions? If yes, please explain ____________________

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Endocrine System (Thyroid/ Parathyroid)

Yes	No	
----	----	Do you consider yourself overweight?
----	----	Have you gained weight recently without changing your lifestyle?
----	----	Is it hard to lose weight even on a diet?
----	----	Have you lost weight recently without trying or wanting to?
----	----	Do you consider yourself underweight?
----	----	Is it hard to gain weight?
----	----	Do you get cold hands and/or feet?
----	----	Have you had hair loss recently?
----	----	Are your fingernails ridged, brittle, or weak?
----	----	Do you have varicose or spider veins?
----	----	Do you have hemorrhoids?
----	----	Do you get muscle cramps often?
----	----	Do you have a problem with bladder leakage?
----	----	Do you have an irregular heartbeat?
----	----	Do you have a heart murmur (Mitral Valve Prolapse)?
----	----	Do you get headaches or migraines often? How often? monthly weekly daily

---- ---- Have you ever had a hernia?
---- ---- Have you ever had an aneurysm?
---- ---- Is your calcium levels low?
---- ---- Is your bone density level low? When was your last bone density scan done?____________
---- ---- Do you have spine deterioration?
---- ---- Do you have any herniated discs?
---- ---- Do you have osteoporosis?
---- ---- Do you have scoliosis (curving of the spine)?

Yes No

---- ---- Do you get irritable easily?
---- ---- Do you have low energy levels?
---- ---- Do you have memory loss or "brain fog"?
---- ---- Do you suffer from symptoms of depression?
---- ---- Have you ever had a goiter?
---- ---- Have you been diagnosed with hyperthyroidism?
---- ---- Have you been diagnosed with hypothyroidism?
---- ---- Have you been diagnosed with Graves' disease?
---- ---- Have you been diagnosed with Hashimoto disease?
---- ---- Have you been diagnosed with Reidel disease?
---- ---- Do you sweat an extreme amount?
---- ---- Do you hardly ever sweat?

Endocrine System (Pancreas)

Yes No

---- ---- Do you get gas after you eat?
---- ---- Do you feel as if your food just sits in your stomach?
---- ---- Do you have Acid Reflux (GERD)?
---- ---- Do you see any undigested foods in your stools?
---- ---- Do you have low blood sugar (hypoglycemia)?
---- ---- Do you have high blood sugar (diabetes)? If yes, circle which one. Type 1 Type 2
---- ---- Are you thin and have a hard time gaining weight?
---- ---- Do you have gastritis or enteritis? If yes, circle which one. Gastritis Enteritis
---- ---- Do you have diarrhea right after you eat?
---- ---- Have you ever been diagnosed with Pancreatitis? If yes, when? ________________

List any other complications or problems not listed above that you are experiencing.

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Digestive System (Gastro-Intestinal Tract)

Yes	No	
----	----	Is your tongue coated (white, yellow, green, or brown) in the morning?
----	----	Do your have a Hiatus Hernia?
----	----	Do you have Celiac disease?
----	----	Do you have abdominal swelling after eating? If yes, how long after eating? ________
----	----	Do you have colitis?
----	----	Do you have diverticulitis?
----	----	Do you get diarrhea? If yes, circle how often. ________
----	----	Do you get constipation? If yes, circle how often. ________
----	----	Have you ever had stomach or intestinal ulcers? If yes, circle which one. stomach intestinal
----	----	Do you have Crohn's disease?
----	----	Do you have your gallbladder?
----	----	Do you have problems with too much "gas"?
----	----	Do you know your current cholesterol levels? If yes, please fill in. LDL ______ HDL ______
----	----	Do you have abnormal stools? Circle all that apply. blood excess mucus float discolored
----	----	How often do you have a bowel movement normally? ________
----	----	Do you have or have you had any type of gastro-intestinal (stomach, colon, rectal) cancers? If yes, please explain the type of gastro-intestinal cancer and any treatment you received: ________ ________
----	----	Have you ever had a colonoscopy? If yes, when? ________ What were the results? ________

Digestive System (Liver/ Gallbladder)

Yes	No	
----	----	Do you have a problem digesting fats?
----	----	Do fats or dairy foods cause bloating and/or pain in the stomach area?
----	----	Do your stools look white or very light brown in color?
----	----	Do you get pain in the middle of you back especially after eating?
----	----	Do you get pain behind the right, lower rib area?
----	----	Do you have "liver" or brown spots on your skin? (*not freckles*)
----	----	Do you have any skin pigmentation changes?
---	----	Do you have skin problems? If yes, please list. ________________________
----	----	Do you have or have you ever had hepatitis? If yes, circle which one. A B C
----	----	Do you have a blood disorder? If yes, circle which one? anemia sickle cell thalassemia

List any other complications or problems not listed above that you are experiencing, including ADHD, OCD or ADD diagnoses.

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Circulatory System (Heart)

Yes	No	
----	----	Do you have any gray hair?
----	----	Do you have a hard time remembering things?
----	----	Do your legs get tired or cramp after you walk?
----	----	Do you bruise easily?
----	----	Do you get chest pains or angina?
----	----	Do you have heart arrhythmias? If yes, what kind? ________________________
----	----	Do your have a heart murmur or Mitral Valve Prolapse?
----	----	Do you ever feel pressure on your chest?
----	----	Do you have or have you ever had high blood pressure?
----	----	Do you get "prickly" pains anywhere on your body, especially the heart area.
----	----	If yes, on what part of your body do you feel these pains? ________________________
----	----	Have you ever had a heart attack (myocardial infarction)?
----	----	Have you ever had open-heart surgery?

---- ---- What is your average blood pressure? ____________________

List any other complications or problems not listed above that you are experiencing.

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Integumentary System (Skin)

Yes No

---- ---- Do you get or have skin rashes?

---- ---- Do you have eczema?

---- ---- Do you have dermatitis?

---- ---- Do you have psoriasis?

---- ---- Do you have dry skin?

---- ---- Do you have dandruff?

---- ---- Is your skin very oily?

List any other complications or problems not listed above that you are experiencing.

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Lymphatic System

Yes No

---- ---- Do you have allergies?

---- ---- Do you ever get cold or flu-like symptoms?

---- ---- Do you have sinus problems?

---- ---- Do you have or get sore throats?

---- ---- Do you have swollen lymph nodes?

---- ---- Do you have a low platelet count (blood)?

---- ---- Do you have a low or sluggish immune system?

---- ---- Do you get boils, pimples, or anything like them?

---- ---- Do you have or ever had abscesses?

---- ---- Do you have or ever had cellulitis?

---- ---- Do you have or ever had gout?

---- ---- Do you get blurred vision?

---- ---- Do you have mucus in your eyes when you wake up in the morning?

---- ---- Do you snore?

---- ---- Do you have sleep apnea? If yes, do you use a CPAP? ____________________

---- ---- Have you had appendicitis or an appendectomy? If yes, when? ____________________

---- ---- Have you ever had toxemia?

---- ---- Have you had your tonsils out? If yes, at what age did this happen? ____________

List any other complications or problems not listed above that you are experiencing.

____

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Urinary System (Kidneys and Bladder)

Yes No

---- ---- Do you have or have you had a urinary (kidney or bladder) infection?

---- ---- Do you have or have you had "burning" upon urination?

---- ---- Do you have problems holding your bladder?

---- ---- Do you have or have you had kidney stones?

---- ---- Do you have bags under your eyes, especially in the morning?

---- ---- Do you get cramping or pain on the left or right side of your mid-to-lower back?

---- ---- Do you have or have you had nephritis?

---- ---- Do you have or have you had cystitis?

---- ---- Is your urine flow restricted?

How much water do you drink in a day? ____________ glasses

List any other complications or problems not listed above that you are experiencing.

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Respiratory System (Lung)

Yes No

---- ---- Do you or have you worked around toxic chemicals, in coal mines, or around asbestos?

---- ---- Do you or have you smoked? If yes, how often? ____________________

---- ---- Do you have pain when you breathe?

---- ---- Do you have pain when you take a deep breath?

---- ---- Do you cough a lot?

---- ---- Do you get any mucus when you cough? If yes, what color is it? ______________________

---- ---- Do you get, have, or have had bronchitis?

---- ---- Do you have or have had pneumonia?

---- ---- Do you get, have, or have had emphysema?

---- ---- Do you get, have, or have had asthma?

---- ---- Do you get, have, or have had C.O.P.D.?

---- ---- Do you have a collapsed lung?

---- ---- Do you have or have you had lung cancer? If yes, when? ______________________

---- ---- Are you on an inhaler? If yes, how often do you use it? ______________________

---- ---- Are you on a nebulizer? If yes, how often do you use it? ______________________

---- ---- Are you on oxygen?

---- ---- Do you know what your oxygen saturation is? If yes, please list. ______________________

List any other complications or problems not listed above that you are experiencing.

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Health History

Family History

Please fill out your family's medical history below.

Family Member	Health Status	Arthritis	Cancer List type	Diabetes	Heart Disease List type	Lung Disease	Mental Illness	Other	Cause of Death	Age at Death
Example: grandfather	deceased	no	brain	no	yes/stroke	no	no	gall bladder disease	brain tumor	52
Grandparents										
Parents										
Siblings										
Children										

Surgeries

Please list any past surgeries you have had such as hysterectomy, tonsils removed, etc.

Year	Surgery

Allergies

Please list any allergies you have.

Allergy (bees, pollen, asprin)	How does it affect you? (rash, watery eyes, stop breathing)

Medications

Please list medications (prescription) you are taking.

Medication	How often?	Why are you taking this medication? example: high blood pressure
Medication (Cont)	How often?	Why are you taking this medication? example: high blood pressure

Supplements

Please list any natural supplements (vitamins, herbal & minerals) you are taking.

Supplement	How often?	Why are you taking this supplement? example: stop constipation

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AUTHORIZATION FORM

I, ______________________________, in affixing my signature to this treatment do thereby agree to and understand the following:

1. That Paul A. Dabney, is a natural health consultant who is legally able to instruct and educate others in self-help methods of health such as the use of proper exercise, diet, nutritional supplements, water, fresh air, rest, and attitude;
2. That Paul A. Dabney, in no context of the phrase "practices medicine" and therefore does not diagnose, prescribe, treat, heal, or otherwise perform a duty that is reserved for those who are licensed to do so;
3. That the instruction concerning a healthful lifestyle is incidental to any particular illnesses and diseases I may have and is therefore not made in direct references to these;
4. Any healing of illnesses or diseases I may experience as a result of following the instruction of Paul A. Dabney, was purely the result of the body itself once a naturally correct way of living was employed, for it is only the body that heals itself, not any person;
5. That no claims or guarantees have been made as to any health benefits that may result from my following the instruction given by Paul A. Dabney, concerning a naturally correct way of living;
6. That the instruction given by Paul A. Dabney, in no way replaces proper medical care, and that I am free to choose a naturally right lifestyle;
7. That under penalty of perjury I am not an agent of any branch of the federal, state, or local government for any agency thereof, with intent to entrap or entice Paul A. Dabney, his staff, employees, and/ or associates into breaking any federal, state, or local law whatsoever, acting either on my own behalf or on behalf of the agency of the government or behalf of any government agency directly;

Signed ____
Date______________________

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PERMISSION & AUTHORIZATION FORM REGARDING THE RECOMMENDATION OF SPECIFIC MEDICAL TESTS, REVIEWING MEDICAL HISTORY AND /OR DEVELOPING NUTRITIONAL HEALTH PLAN

PLEASE READ BEFORE SIGNING

I specifically authorize Paul A. Dabney, N.M.D., M.P.H., M.Ed., a non-licensed Naturopathic and Integrative Medicine Consultant, to recommend specific testings, review medical history and/ or developing nutritional health plan for me that may include dietary guidelines, nutritional supplements, ect., in order to assist me in improving my health **and not for the treatment or "cure" of any disease**.

I understand that nutritional determination testing is safe, non-invasive and uses natural methods of analyzing the body's physical and nutritional needs, and that deficiencies or imbalances in these areas could cause or contribute to various health problems.
I understand that nutritional determination testing(s) is / are not methods for "diagnosing" or the "treatment" of any disease or medical condition.

No promise or guarantee has been made regarding the results of any tests or any natural health, nutritional or dietary recommended, but rather I understand that these tests are ways by which the body's responses can be used as an aid to determine possible nutritional imbalances, so that safe, natural programs can be developed for the purpose of bringing about a better state of health.
I have read and understand the forgoing. This permission form applies to subsequent visits and consultations.

Print Name ____________________________________
Address______________________________________
City____________________ State________ Zip code_______________
Home phone _____________________
Cell phone_____________________
Signed_____________________________________ Date____________
(If minor, signature of parent or guardian required)

Advanced Medical and Chiropractic Services

PATIENT ACKNOWLEDGEMENT AND CONSENT

I have been given a copy of AMNCS' Notice of Privacy Practices. I consent to the uses and disclosure of my health information as outlined in the Notice of Privacy Practices.

______________________________ ____________________
Signature of Patient or Representative Date

____
Printed Name of Patient

____
Printed Name of Representative

Please describe the Representative's authority to act on behalf of the Patient **(initial one).**

( ) The representative is the parent of the patient, who is a minor.

( ) The representative is the guardian of the patient, who has been adjudicated incompetent.

( ) The representative is acting under a Durable Power of Attorney for Health Care for the patient, and has presented a copy of this document to AMNCS.

( ) I authorize/give my consent to the person(s) below to discuss my PHI. I understand that I may revoke this authorization at any time by giving written notice to AMNCS:

1. ____________________ (Name) ____________________ (Relationship)
2. ____________________ (Name) ____________________ (Relationship)
3. ____________________ (Name) ____________________ (Relationship)

FOR OFFICE USE ONLY

If acknowledgement of receipt of the Notice of Privacy is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and reason you could not obtain it.

____
____