Abundant Health & Wellness Center, Inc.
216 River Park North Dr, Woodstock, GA 30188 | 678-445-2746

New Patient Health History Form

All information is strictly CONFIDENTIAL.

Type in the fields, then print and sign by hand.

Patient data

First Name _____ Last name _____ Date _____

Email _____ Age _____ Birth date _____

Your email will not be shared with third parties and is used for occasional office announcements and promotions.

Social Security number _____ Number of children _____ Referred by _____

Mailing address and contact information

Street address _____

City _____ State _____ ZIP _____

Cell phone number _____ Telephone work _____ Telephone home _____

Occupation _____ Employer _____

Marital status _____ Spouse name _____

Spouse occupation _____ Spouse employer _____ Spouse health status _____

Emergency contact _____ Phone _____

Current complaints

Nature of injury: ☐ Automobile* ☐ Work ☐ Other

Please describe _____

Date of injury _____ Date symptoms appeared _____

Have you ever had the same condition? ☐ No ☐ Yes If yes, when? _____

List other practitioners seen for this injury or condition: _____

Have you ever been under chiropractic care? ☐ No ☐ Yes If yes, describe: _____

Insurance information

Party responsible for payment _____ Phone _____

Health insurance? ☐ No ☐ Yes Company: _____

*Auto accident: Insurance company _____ Contact person _____

Phone _____ Claim number _____

Signatures

Name of the insured: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient signature _____ Date _____

Spouse or guardian signature _____ Date _____

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Medical History

Treated for any conditions in the last year? ☐ No ☐ Yes Describe: _____
Date of last physical exam _____ Chance of pregnancy? ☐ No ☐ Yes
Have you had X-rays taken? ☐ No ☐ Yes If yes, where? _____
What medications are you taking and for what conditions? Include doses and amounts.

_____

_____

What vitamins, minerals, or herbs do you currently take? Include conditions, doses, and frequency.

_____

_____

Have you ever	No	Yes	Briefly explain
Broken bones	☐	☐	
Been hospitalized	☐	☐	
Been in an auto accident	☐	☐	
Had sprains or strains	☐	☐	
Been struck unconscious	☐	☐	
Had surgery	☐	☐	

Family history

Family members present and past health conditions (heart disease, cancer, diabetes, arthritis, etc.).

_____

_____

Do you experience pain every day? ☐ No ☐ Yes
Do your symptoms interfere with daily life? ☐ No ☐ Yes
Does pain wake you up at night? ☐ No ☐ Yes
Are your symptoms worse during certain times of the day? ☐ No ☐ Yes
Do changes in weather affect your symptoms? ☐ No ☐ Yes
Do you wear orthotics? ☐ No ☐ Yes
Do you take vitamin supplements? ☐ No ☐ Yes
What activities aggravate your symptoms?

_____

Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Sugary foods	☐	☐	☐	☐
Artificial sweeteners	☐	☐	☐	☐

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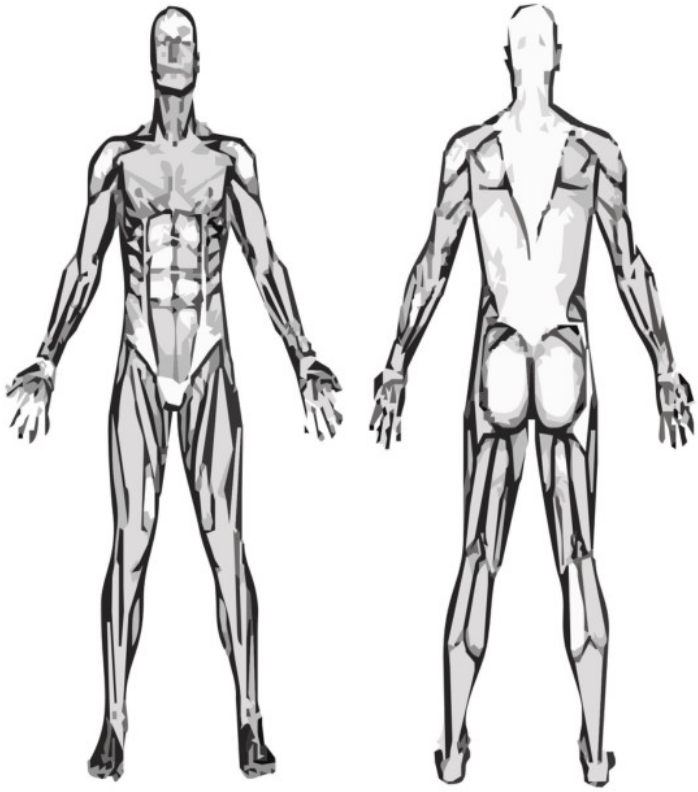
Health Conditions and Symptom Locations

Have you ever suffered from

☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma
☐ Back pain
☐ Breast lump
☐ Bronchitis
☐ Bruise easily
☐ Cancer
☐ Chest pain or conditions
☐ Cold extremities
☐ Constipation
☐ Cramps
☐ Depression
☐ Diabetes
☐ Digestion problems
☐ Dizziness
☐ Ears ring
☐ Excessive menstruation
☐ Eye pain or difficulties
☐ Fatigue
☐ Frequent urination
☐ Headache
☐ Hemorrhoids
☐ High blood pressure
☐ Hot flashes
☐ Irregular heartbeat
☐ Irregular cycle
☐ Kidney infection
☐ Kidney stones
☐ Loss of memory
☐ Loss of balance
☐ Loss of smell
☐ Loss of taste
☐ Lumps in breast
☐ Neck pain or stiffness
☐ Nervousness
☐ Nosebleeds
☐ Pacemaker
☐ Polio
☐ Poor posture
☐ Prostate trouble
☐ Sciatica
☐ Shortness of breath
☐ Sinus infection
☐ Sleep problems or insomnia
☐ Spinal curvatures
☐ Stroke
☐ Swelling of ankles
☐ Swollen joints
☐ Thyroid condition
☐ Tuberculosis
☐ Ulcers
☐ Varicose veins
☐ Venereal disease
☐ Other: _____

Indicate the TYPE and LOCATION of your current symptoms on the diagrams.

A = Ache B = Burning N = Numbness
O = Other P = Pins and needles S = Stabbing







Typing? List symptom type and location here.

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Authorization and Financial Policies

Please complete and sign. Ask the office about any term you do not understand.

Patient full name _____ Date of birth _____

General authorization

I authorize examination and chiropractic-related care for myself or the minor or person under my legal guardianship named above. I understand that results cannot be guaranteed. Specific procedures, their risks, benefits, and alternatives should be discussed with the clinician before I consent to them. This general authorization does not replace that discussion or any procedure-specific informed consent.

If signing for the patient: representative name and relationship _____

Patient or legal representative signature _____ Date _____

Payment for services

Payment is due when services are rendered unless other arrangements have been made. Fees are based on the individual services rendered and may vary according to the doctor's recommendations. Health and accident insurance policies are an arrangement between the patient and the insurance carrier. I am personally responsible for services rendered and missed appointments. The office will provide reasonable assistance in filing an insurance claim.

Account balances 30 days past due are subject to a charge of 1.5% per month (18% per year). Accounts sent to collection are subject to an additional charge of 35% of the amount due, in addition to any assessed interest and collection fees.

Cancellations and prepaid packages

Please notify the office of cancellations at least 24 hours before the scheduled appointment. A missed appointment will result in either a $50 fee or, for a prepaid package, deduction of one visit from the package. Prepaid packages must be used within nine months or will be terminated. There are **no refunds or exchanges on nutritional supplements**, packages purchased, or services received.

I have read, understand, and accept the financial and cancellation policies above.

Patient or guarantor signature _____ Date _____

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Privacy Notice Acknowledgment

Give the patient the practice's current Notice of Privacy Practices with this page.

Patient full name _____ Date of birth _____

Acknowledgment of receipt

I acknowledge that I have received the Notice of Privacy Practices for Abundant Health & Wellness Center, Inc. The notice explains how my protected health information may be used or disclosed, my privacy rights, and how to contact the practice about privacy questions or complaints.

My signature acknowledges receipt of the notice. It does not authorize publication of my information, waive my privacy rights, or grant permission for uses or disclosures that require a separate authorization.

Patient or legal representative signature _____ Date _____

If applicable: representative name and legal authority to sign _____

Optional permission to discuss care

Please indicate whether the practice may discuss information relevant to your care or payment with the people you identify below. Leaving this section blank does not grant additional permission. Disclosures otherwise permitted or required by law may still occur.

☐ Yes - only the people and information listed below
☐ No additional permission at this time

Name _____ Relationship and phone _____

Name _____ Relationship and phone _____

Information that may be discussed and any restrictions

_____

_____

_____

I may change or withdraw this optional permission by notifying the practice in writing. A change does not undo disclosures already made in reliance on my permission.

Signature for optional permission _____ Date _____

Office: document separately if acknowledgment could not be obtained, including efforts made and the reason.

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Biofeedback Scans

Optional service - complete only if the practice recommends this screening.

Patient full name _____ Date of birth _____

The practice offers computerized biofeedback screening using the systems identified below.

Proposed system - office to identify

☐ Quest ☐ Asyra ☐ CST ☐ ASA

Reason for visit

Main concerns, in order of importance

_____

_____

If your medications, supplements, and surgeries are already listed in your health-history form, write "See health history" below and add any changes.

Medications and supplements, including doses and reasons

_____

_____

_____

Surgeries and dates

_____

Understanding and choice

I understand that this screening does not provide a medical diagnosis or replace evaluation by my medical doctor. Its results do not diagnose food allergies or any specific disease. Medical concerns may require separate evaluation or testing.

The technician does not become my primary care physician by performing this screening. Any recommended program or products are optional, and results are not guaranteed. I may ask questions and decline screening or recommendations. **The practice's stated policy is that testing fees and purchased products are nonrefundable.**

I consent to the system or systems selected above.

Patient or legal representative signature _____ Date _____

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Notice of Privacy Practices

Effective October 19, 2026

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. It applies to our paper and electronic protected health information.

Privacy contact: Ilana Ambrosio | 678-445-2746 | info@ahwcinc.com Send requests or complaints to this contact or the office address above. Ask about secure options before sending sensitive information by email.

Your rights

Access records. Ask to inspect or obtain paper or electronic copies of records we maintain about you. We generally respond within 30 days; any permitted extension will be explained in writing. Reasonable, cost-based fees may apply. We explain denials and available review rights.

Request corrections. Ask us to amend information you believe is incorrect or incomplete. We generally respond within 60 days and explain any permitted extension. If we deny your request, we explain why and how to submit a statement of disagreement.

Confidential communication. Ask us to contact you at a particular address or telephone number or in a specific way. We accommodate reasonable requests.

Request limits. Ask us to limit uses or disclosures for treatment, payment, or operations. We generally need not agree, but follow accepted restrictions, subject to legal exceptions such as emergency treatment. If you pay in full out of pocket for a service or item, you may ask us not to share related information with your health plan for payment or operations. We honor that request unless disclosure is required by law.

Disclosure accounting. Request a list of certain disclosures during the preceding six years. Exceptions include treatment, payment, operations, and disclosures you authorized. One accounting per 12 months is free; we tell you any reasonable, cost-based fee for additional requests.

Copies and representatives. Obtain a paper copy of this notice at any time, even after agreeing to electronic delivery. A legally authorized personal representative may exercise applicable rights for you; we verify authority and follow applicable exceptions, including protections for minors and abuse or endangerment situations.

Our responsibilities and complaints

We protect your information, follow this notice, provide you a copy, and notify affected individuals of breaches as required by law. Complain to our privacy contact or to HHS Office for Civil Rights, 200 Independence Avenue, S.W., Washington, DC 20201; 1-877-696-6775; https://www.hhs.gov/hipaa/filing-a-complaint/index.html. We will not retaliate.

We may revise this notice and apply lawful revisions to existing and new information. The current notice is available on request, in our office, and on our practice website; its effective date appears above.

Please keep this notice for your records.

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How We Use and Share Information

Care and practice operations

Treatment: We use information to provide and coordinate care and share it with professionals treating you, such as discussing findings with another clinician. Payment: We use or share information to bill and obtain payment, such as submitting a claim to an insurer. Operations: We use or share information to manage records, assess quality, improve care, and operate the practice. Providers handling information for us must protect it as required by law and agreements. We may contact you about appointments, care, treatment alternatives, or related services as legally permitted.

Your choices and written permission

Family and others: Tell us what relevant information we may share with people involved in your care or payment. We seek agreement or follow other permission allowed by law. If you cannot express a preference, professional judgment may permit sharing in your best interests. Disaster-relief disclosures may also be permitted. Record optional choices on the separate acknowledgment page.

Authorization: Written authorization is required for most uses of psychotherapy notes, sale of protected information, and marketing requiring authorization. Other uses not described here require authorization unless law permits or requires them. This notice is not permission to publish identifiable stories, images, or testimonials. Revoke authorization in writing, except where we have already relied on it or another legal exception applies; otherwise lawful disclosures may continue.

Other uses and disclosures permitted by law

When applicable legal conditions and safeguards are met, we may use or share information for public health reporting, product recalls, adverse reactions, abuse or neglect reporting, preventing serious and imminent threats, health oversight, workers' compensation, law enforcement, court or administrative proceedings, research, organ or tissue donation, coroners, medical examiners, funeral directors, and specified military, national security, or other government functions. A request or subpoena alone does not automatically authorize disclosure. We disclose when required by law, including to HHS for compliance review.

Additional protections

Substance use disorder records: If we hold records protected by 42 CFR part 2, we will not use or disclose those records, or testimony about their contents, in civil, criminal, administrative, or legislative investigations or proceedings against you without your written consent or a court order and a subpoena as required by law. Other Part 2 uses and disclosures must also meet applicable requirements.

Georgia and other laws: We follow more protective laws where applicable, including Georgia restrictions on certain HIV/AIDS, mental health, developmental disability, and substance use treatment records. We obtain required permission or disclose only under a specific legal exception. General permissions here do not override those protections.

Keep this notice. Sign the separate acknowledgment to confirm receipt. Signing does not waive your privacy rights.

Please keep this notice for your records.