Welcome to Atma Clinic

Congratulations on taking the first steps towards healing and optimal wellness! We are excited to journey alongside you as we work together to help you achieve your personal health goals.

Communication:

- Excellent communication is part of excellent care. Please feel free to call, text or send us a message through your patient portal any time with any need. Lawrence office hours are Monday - Friday 8am-4pm. Overland Park office hours are Monday - Thursday, 8am-4pm. Calls received after these times will be returned on the next business day. Please leave a message. If a message is not left, your call will not be returned. If you have a more pressing need please send a detailed text message or email outlining your symptoms, concerns and questions. This will ensure we get adequate details to provide the appropriate response. You may also send your provider a direct message through your patient portal.
- **Atma clinic Lawrence phone number: 785-760-0695 email**: admin@atmaclinic.com
- **Atma clinic OP phone number: 913-568-0608 email:** info@atmaclinic.com
- For pressing medical needs outside office hours please use the nurse line: 785-764-4050.
- Administrative issues may not be returned on weekends. However, all clinical issues should be returned in a timely manner. **We will answer phone calls within 24 hours**. We will answer any **patient portal messages or emails within 48 hours. If you do not hear back from us within these times, please contact us again**. If you still feel as if you are having difficulty getting a timely response please contact our clinic manager Sydney Georgie.
- Atma Clinic is committed to providing a safe, secure and respectful environment for our patients and staff. Any words or actions that are threatening or demeaning will not be tolerated and decisive actions taken to protect our patients and staff. Please notify Sydney Georgie or Crystal Olmsted immediately with concerns.

Emergency Care Policy:

- Atma Clinic does not provide Emergency Services. **If you have a medical emergency call 911 and report to your nearest Emergency Room.** Similarly, we do not provide urgent care services. We cannot be responsible for any delays in care. Please contact the office once the situation has stabilized so that your provider can coordinate with the Emergency Room or Urgent Care staff as necessary.

Appointment setting:

- When you need to schedule an appointment you may call, text or, go to the patient portal to request an appointment. At each appointment you will go through a routine doctor's office check-in. We will get blood pressure, pulse, review medical history and medications along with collecting any due payments.

Appointment Cancellations:

- It is your responsibility to notify us at least 24 business hours in advance Monday thru Saturday if you need to cancel your appointment. **Missed appointments and late cancellations will be billed at the standard appointment rate.**

Clinic Closure:

- We may cancel your appointment for inclement weather, or in the event of severe illness of your provider. Typically, we will close the clinic if there are icy conditions significant enough to create school closures or trigger other government notices. We will notify you as soon as the decision is made. If you have any questions about the adequacy of conditions on a given day, please call your rendering providers office to confirm your appointment.

Lab protocol:

- Lab appointments are scheduled Monday-Friday mornings. For most labs you will need to be fasting. This means nothing to eat or drink besides water 10-12 hours prior to your appointment time. Please remember that it is fine to drink water and we encourage you to do so up until your appointment.
- Most blood work can be drawn by our staff in our office. Some blood work can be drawn elsewhere, if you desire. However, some specialty labs MUST be drawn in our office. **Please note that there is a $25 venipuncture fee associated with in-house lab draws**. We do our best to schedule all draws in the same appointment to ensure that no more than one fee is applied.
- **Atma Clinic does not bill insurance for routine lab draws**. We have negotiated discounted prices with Labcorp for routine labs which you have access to with your membership.

Supplements:

- There is a good chance that your plan will include a combination of herbs and supplements. We use an online dispensary called Full Scripts for prescribing. Once we have implemented your plan, you will receive an email with a link to your prescribed supplements. If at any time you are unable to login to your Full Scripts account or have any questions about a supplement, please give us a call. If you are able to find the exact prescribed supplement elsewhere for less cost please feel free to purchase it. If you get onto Full Scripts to re-order and your supplement is no longer available or on back stock please give our office a call so that we can send you an alternative.

Financial Policy:

- **Payment is due at the time of service.** In certain cases, a payment plan may be offered. If a payment plan is arranged, it is your responsibility to ensure that the card on file remains active and to promptly update us with any changes to your payment information. Please note that a failed charge may incur a service fee of $25.

Neela Sandal, MD
Lauren Poull, MD
Conner Keyeski, APRN, FNP-C
Susan Dreger, APRN, FNP-C
Lisa Cason, APRN
David Lovely, LMAC, LPC, ACHt
Ashley Combs, BSND

Dear Caregiver,

Thank you for taking the time to fill out this questionnaire. It is extensive, but history plays a vital role in Integrative Medicine, so your time and accuracy in filling out this document will allow me to best serve your child, you, and your family.

If your child is old enough, please ask them to participate in filling out the form, particularly the REVIEW OF SYMPTOMS. For areas that do not apply, please put “N/A” rather than leave them blank. If there is something that you do not know or are unclear about, please let me know by placing a question mark by that item.

Please bring all medication and supplements your child is taking or a picture of the label with the dose/ingredients to the appointment. Also, bring any laboratory tests, other types of studies, and vaccine records to your first appointment.

If you have any questions, please call either of our office locations. I look forward to working together.

Lauren Poull MD, FAAP

GENERAL INFORMATION

Name: _____
First *Middle* *Last*

Preferred Name: _____ Date of Birth: _____ Age:_____

Gender: ☐ Male ☐ Female

Genetic Background: ☐ African ☐ European ☐ Native American ☐ Mediterranean

☐ Asian ☐ Ashkenazi ☐ Middle Eastern ☐_____

Mother's/Guardian Name:_____Occupation: _____

Father's/Guardian Name:_____Occupation: _____

Home Phone_____Work Phone_____

Mother's Cell Phone:_____Father's Cell Phone: _____

Fax: _____ Email: _____

Emergency Contact

Name: _____Phone: _____

Address:_____

City, State, Zip:_____

Physician

Name:_____Phone: _____

Fax: _____

Referred by:

☐ Website ☐ Media ☐ Friend/Family Member ☐ Other_____

COMPLAINTS/CONCERNS

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair

What do you hope to achieve in your visit? _____

_____

If you had a magic wand and could help your child in three ways, what would they be? (GOALS)

1._____

2._____

3._____

When the last time you felt your child was well? (ONSET of problem)_____

Did something trigger your child's change in health?_____

_____

Is there anything that makes your child feel worse?_____

Is there anything that makes your child feel better?_____

Has your child tried complementary, integrative or alternative therapies in the past? ◻ Yes ◻ No

Name of therapy	For what condition	Duration of therapy	Improvement seen
			◻ Yes ◻ No
			◻ Yes ◻ No
			◻ Yes ◻ No

PAST MEDICAL HISTORY (check what applies)

Past	Current	
		MUSCULOSKELETAL/PAIN
		Fibromyalgia
		Chronic Pain
		Scoliosis
		Broken bones
		SKIN DISEASES
		Eczema
		Rashes
		Acne
		Other
		GENITAL AND URINARY
		Kidney Stones
		Urinary Tract Infections
		Yeast Infections
		Bedwetting
		GASTROINTESTINAL
		Irritable Bowel Syndrome
		Constipation
		Crohn's / Ulcerative Colitis
		GERD (reflux)
		Celiac Disease
		Other
		CARDIOVASCULAR
		Congenital heart disease
		High cholesterol
		Fainting/dizziness
		Heart murmur
		Irregular heart rate
		RESPIRATORY DISEASES/ENT
		Frequent Ear Infections
		Chronic cough
		Asthma
		Chronic Sinusitis
		Sleep Apnea
		Other
		INFLAMMATORY/AUTOIMMUNE
		Chronic Fatigue Syndrome
		Autoimmune Disease
		Rheumatoid Arthritis

Past	Current	Immune Deficiency Disease
		Frequent infections
		Food Allergies
		Environmental Allergies
		Multiple Chemical Sensitivities
		Vaccine reactions
		PANDAs
		Valley fever
		Cancer
		Other
		METABOLIC/ENDOCRINE
		Diabetes
		Prediabetes
		Hypoglycemia
		Thyroid problems
		Polycystic Ovarian Syndrome (PCOS)
		Weight Gain or loss
		Early/ late sexual development
		NEUROLOGIC
		Vision problems/glasses
		Hearing problem
		Headaches
		Cerebral palsy
		Low/High muscle tone
		Mild Cognitive Impairment
		Delays in development
		Seizures
		Concussions
		Other Neurological Problems
		MOOD/BEHAVIOR
		Depression
		Anxiety
		ADD/ADHD
		Sensory Integrative Disorder
		Autism/ Austin spectrum
		Down syndrome
		Genetic problems

HOSPITALIZATIONS ☐ None

Age	Reason

PREVIOUS EVALUATIONS *(provide dates)*

Date	
	Blood Tests
	Genetic Evaluation
	Neurological Evaluations
	EEG or qEEG
	Gastroenterology Evaluations
	Evaluation for learning disability
	Allergy Evaluation
	Auditory Evaluation
	Vision Evaluation
	Physical Therapy
	Occupational Therapy
	Speech Therapy
	Sensory Integration Therapy
	Chiropractic
	MRI
	CT Scan
	Upper Endoscopy
	Upper GI Series
	Ultrasound
	Other alternative therapies
	Other specialists seen

SURGERIES

Age	
	Appendectomy
	CIrcumcision
	Hernia
	Tonsils
	Adenoids
	Detal Surgery
	Tubes in Ears
	Other

IMMUNIZATIONS

☐ Up to date
☐ Partially immunized
☐ Vaccines declined

DENTAL HISTORY

☐ Child has cavities now or in the past
☐ Mercury fillings ☐ Root Canals
☐ Tooth pain ☐ Bleeding gums ☐ Dental caps
☐ Gingivitis ☐ Chewing problems
Does child floss regularly? ☐Yes ☐No

MEDICAL SYMPTOM QUESTIONNAIRE

BASED ON THE PAST 30 DAYS rate each of the following symptoms based on your child's health profile.
Mark numbers 0-4 next to each item based on the following scale:

0. Never or almost never 1. Occasionally have it, effect not severe 2. Occasionally have it, effect is severe

3. Frequently have it, effect not severe 4. Frequently have it, effect is severe

Joints/Muscles	**Scale**
Pain or aches in joints	
Stiffness or limitation of movement	
Pain or aches in muscles	
Muscle weakness, tiredness	
Total	
Skin	**Scale**
Acne	
Hives, rashes, eczema, dry skin	
Hair loss	
Excessive sweating	
Total	
Genitourinary	**Scale**
Frequent/urgent urination	
Genital itch or discharge	
Total	
Digestive	**Scale**
Nausea or vomiting	
Diarrhea	
Constipation	
Bloating	
Passing gas/ belching	
Heartburn	
Abdominal pain	
Total	
Weight	**Scale**
Excessive eating/drinking	
Craving certain foods	
Excessive weight	
Underweight	
Compulsive eating	
Total	

Lungs	**Scale**
Chest congestion	
Asthma/bronchitis	
Difficult breathing	
Chronic cough	
Total	
Heart	**Scale**
Irregular heartbeat	
Rapid or pounding heartbeat	
Chest pain	
Total	
Mouth	**Scale**
Gagging, throat clearing	
Sore throat, hoarse voice	
Swollen/discolored tongue, gums, lips	
Canker sores	
Total	
Nose	**Scale**
Stuffy nose/ excessive mucous	
Sinus problems	
Nose allergies/ sneezing	
Frequent infections	
Nose bleeding	
Total	
Ears	**Scale**
Ear infections/pain	
Itchy ears	
Drainage from ear	
Ringing in ear/ hearing loss	
Total	
Eyes	**Scale**
Watery or itchy eyes	
Swollen, red or sticky eyelids	

Dark circles under eyes	
Blurry vision (does not include near of far sightedness	
Total	
Head	**Scale**
Headache	
Fainting	
Dizziness	
Insomnia	
Total	
Mind	**Scale**
Poor concentration	
Poor understanding, confusion	
Poor memory	
Poor physical coordination	
Difficulty making decisions	
Speech problems	
Learning disabilities	
Total	
Emotions	**Scale**
Mood swings	
Anxiety, fear or nervousness	
Anger irritability or aggressiveness	
Depression/ sadness	
Obsessions/ compulsions	
Total	
Energy/Activity	**Scale**
Hyperactivity	
Sluggish/ fatigue	
Restlessness	
Apathy, lethargy	
Total	

Grand Total_____

Key: Total score less than 10 – optimal; 10-50 – mild toxicity; ; 50-100 – moderate toxicity; Over 100 severe toxicity

FAMILY HISTORY

	Check biological family members that apply.	Mother	Father	Brother(s)	Sister(s)	Other
Skin	Eczema / Psoriasis					
Genito urinary	Kidney stones, kidney disease					
	Frequent urinary infections					
Gastro intestinal	Inflammatory Bowel Disease/ irritable bowel					
	Celiac Disease (Wheat Sensitivity)					
	Food Allergies, Sensitivities or Intolerances					
	Gallbladder disease					
	Hepatitis/ Liver problems					
Cardiovascular	High Cholesterol					
	High blood pressure					
	Heart Disease/Heart attack					
Respiratory	Asthma/ Lung problems					
Metabolic	Obesity					
	PCOS					
Endocrine	Diabetes					
	Thyroid problems					
	Stroke					
Inflammatory, immune	Inflammatory Arthritis (rheumatoid, Psoriatic, Ankylosing Spondylitis, Lupus)					
	Environmental Sensitivities					
	Chronic fatigue/ Fibromyalgia					
Neuro	Migraines/ Headaches					
	Multiple Sclerosis					
	Seizures/ neurologic problems					
Psychiatric Disorders	Substance Abuse (alcohol, drugs)					
	Anxiety					
	Depression					
	Schizophrenia, Autism					
	ADHD/ADD					
	Bipolar Disease					
	Learning problems,					
Other	Anemia/sickle cell					
	Genetic Disorders					
	Cancers					
	Deceased					
	OTHER Family Diseases: (list below)					

MEDICATIONS/ SUPPLEMENTS

Current Medications ◘ **None**

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

Previous Medications: *Last 7 years (attach list if appropriate)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy) □ **None**

Supplement and Brand	Dose	Frequency	Start Date (month/year)	Reason for Use

Allergies

Medication/Supplement/Food	Reaction

Has there been prolonged use of anti-inflammatory medication (Advil, Motrin, Aspirin etc.)? ☐Yes ☐No

Has there been prolonged use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? ☐Yes ☐No

Frequent antibiotics > 3 times/year ☐Yes ☐No

Used antifungal, anti-parasitic medication ☐Yes ☐No

Use of steroids (prednisone, nasal/asthma allergy inhalers) in the past ☐Yes ☐No

Use of oral contraceptives ☐Yes ☐No

Has your child taken antidepressants, antipsychotics, stimulants or ADHD medication before? (If yes, how many times?)

Name of Medicine	Month/Year Taken	Condition	Dosage and Length of Treatment

PATIENT BIRTH HISTORY

Mother's Past Pregnancies

Number of pregnancies _____ Live Births _____ Miscarriages _____

Mother's Pregnancy

- ☐ Difficulty getting pregnant (more than 6 months)
- ☐ Infertility drugs used
  Type_____
- ☐ In vitro fertilization
- ☐ Drink alcohol
- ☐ Drink coffee
- ☐ Smoke tobacco
- ☐ Take antibiotics
- ☐ Take antibiotics during labor
  Type_____
- ☐ Take other drugs
  Type_____
- ☐ Have a viral infection
  Type_____
- ☐ Have a yeast infection
- ☐ Have physical or emotional trauma
- ☐ Medication during pregnancy
  Type_____
- ☐ Have birth problems
- ☐ Group B strep infection
- ☐ Have C-section
  Reason_____
- ☐ Use induction for labor (such as Pitocin)
- ☐ Have anesthesia
  Type_____
- ☐ Have an x-ray
- ☐ Gestational Diabetes
- ☐ High blood pressure (pre-eclampsia)
- ☐ Postpartum depression
- ☐ Have chemical exposure
  Type_____
- ☐ Move to a newly built house
- ☐ House painted indoors/outdoors
- ☐ House exterminated for insects
- ☐ Other_____
  _____

PERINATAL

Pregnancy duration: *How many weeks of gestation?*_____ Weight at birth:_____lbs. ___oz.

Hospital/Birthing Center? ☐Yes ☐No
Needed Newborn Special Care / NICU? ☐Yes ☐No
Easily consoled during first month? ☐Yes ☐No
Suffered from colic or reflux ☐Yes ☐No

BREASTFED HISTORY

Breastfed? ☐Yes ☐No

Exclusively breastfed for how many months? _____

BOTTLEFED HISTORY

Bottle fed? ☐Yes ☐No Type of formula?
Introduction to cow's milk at what age?
Introduction to solid foods at what age?
Choke/Gas/Vomit on milk? ☐Yes ☐No

Please describe any other eating concerns that you have regarding your child:_____

_____

EARLY CHILDHOOD ILLNESSES

Number of earaches in the first two years? _____
Number of other infections in the first two years? _____
How many course of antibiotics in the first two years? _____

First antibiotic at _____ months

Vaccine reactions: _____

Constipation or digestive issues:_____

_____

DEVELOPMENTAL PROBLEMS

☐ None

If your child has developmental problems, at what age did they occur?	_____
Choose from the following three scenarios:	
Your child hit milestones and spoke on time, then abruptly changed and was "lost".	☐Yes ☐No
Your child never hit milestones and did not speak on time.	☐Yes ☐No
Your child was developing normally, then hit a plateau (no abrupt change)	☐Yes ☐No

GYNECOLOGIC HISTORY *(For female patients ONLY)*

Menstrual History

Age at first period: _____ Menses frequency: _____ Length: _____

Pain: ☐Yes ☐ No Clotting: ☐Yes ☐ No

Regular periods? ☐Yes ☐ No Last period: _____

Use of hormonal contraception such as ☐birth control pills ☐patch ☐implantable ☐IUD

Length of time: _____

NUTRITIONAL HISTORY/ DIGESTION

Is your child following a special diet or does he or she have specific dietary limitations or needs based on health, ethnic, cultural, or religious preferences? ☐Yes ☐ No

Please explain:_____

☐Organic foods ☐Partially organic foods ☐Non organic foods ☐Canned or farmed fish

Does your child avoid any particular foods? ☐Yes ☐No

If yes, what types and reason: _____

If your child could pick his/her favorite foods per day what would that be? What are his/her food cravings?

_____

Who does the shopping in your household? _____

Who is involved in preparing food for and feeding your child? Check all that apply.

☐Self ☐other parent ☐school ☐daycare ☐in-home care ☐grandparent

Which of the following beverages does your child drink and how cups per day may?

☐Water_____ ☐milk_____ ☐milk alternative_____ ☐juice_____ ☐soda/diet soda_____ ☐Other _____

How many meals does your child eat out per week? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐More than 5 meals per week

How many meals per day does your child eat _____ How many snacks per day_____

Check all the factors that apply to your current lifestyle and eating habits:

- ☐ Low fruit / vegetable intake
- ☐ High sugar / sweets intake
- ☐ Caffeine intake / caffeinated drinks
- ☐ Fast eater
- ☐ Erratic eating patterns
- ☐ Eats too much
- ☐ Poor snack choices
- ☐ Sensory issues with food
- ☐ Picky eater
- ☐ Processed foods
- ☐ Limited variety of foods <5/day
- ☐ Every meal is a struggle
- ☐ Most family meals together
- ☐ Use food as a bribe or reward
- ☐ Most meals eaten at the table
- ☐ TV or videos with meals
- ☐ Eating late at night
- ☐ Eating for comfort

DIGESTION

How many stools per day does child have _____

Are your child's stools	☐Hard	☐Large	☐Pebble like	☐Require straining?
	☐Soft	☐Loose	☐Watery	☐Alternating diarrhea/constipation
Gas?	☐Often	☐Sometimes	☐Rarely	
Bloating?	☐Often	☐Sometimes	☐Rarely	
Stomach Pain?	☐Often	☐Sometimes	☐Rarely	
Nausea/Vomiting?	☐Often	☐Sometimes	☐Rarely	

LIFESTYLE

SLEEP/REST

Average number of hours your child sleeps per night: _____

Does your child have trouble falling asleep? ☐Yes ☐No

Trouble staying asleep? ☐Yes ☐No

Does your child feel rested upon awakening? ☐Yes ☐No

Does your child snore? ☐Yes ☐No

Takes medicine for sleep ☐Yes ☐No

ACTIVITY

How much time does your child spend watching TV? _____

How much time does your child spend on the computer or playing videogames? _____

How much time does your child spend outside per day?_____

☐Daily ☐ Few times per week ☐Weekly ☐Less than weekly

How often does your child read or how often does someone read to your child?_____

Child enrolled in sports ☐Yes ☐No

Activity		Frequency	

RISK

Does anyone in your child's household smoke?	☐Yes	☐No
Has your child been exposed to or used street drugs or alcohol?	☐Yes	☐No
Are there guns in the house?	☐Yes	☐No

PSYCHOSOCIAL

Has your child experienced any major life changes that may haveimpacted his/her health?

_____

Has your child ever experienced any major losses/trauma? (please detail)

_____

Has your child ever been abused, a victim of a crime, or experienced a significant trauma?

_____

STRESS/COPING

Does your child have a favorite toy or object?_____

What are your child hobbies and interests? _____

What are your child favorite activities?_____

Check all that apply: ☐Yoga ☐Meditation ☐ Imagery ☐Breathing ☐Tai Chi ☐Prayer ☐Other:_____

Does your child feel stressed? ☐Yes ☐No Stress sources: ☐ family ☐school ☐health

Do you feel stressed? ☐Yes ☐No

Resources for emotional support for you and child*:*

❑Family ❑Friends ❑Religious/Spiritual Pets ❑Other: _____

LEARNING

Child attends ❑public school ❑charter school ❑home schooling

How is your child's academic performance? ❑in gifted program ❑straight A's ❑average

❑failing classes ❑Has IEP plan ❑is in special education ❑has 504 plan

Behavior problems in school? ❑Yes ❑No Is it easy to make friends? ❑Yes ❑No

SOCIAL SITUATION

List family members living in the house:

Name of Family Member and Relationship	**Age**	**Occupation**

Pets in the house _____ In how many homes does child live?_____

SOME THINGS ABOUT *PATIENT'S* PARENTS

When were parents married:_____ If separated, when: _____

If divorced, when:_____ If remarried, when: _____

Custody arrangements: _____

MOTHER - PERSONAL		**FATHER - PERSONAL**	
Age at childbirth	_____	Age at childbirth	_____
Education	_____	Education	_____
Ethnicity	_____	Ethnicity	_____

ENVIRONMENTAL HISTORY

Please check appropriate box (INCLUDE DATES)

Past	Current	None	Date	
☐	☐	☐		Mold in bathroom
☐	☐	☐		Mold visible on exterior of house
☐	☐	☐		Mold in school/daycare
☐	☐	☐		Pest extermination
☐	☐	☐		Close to area treated with herbicides, fungicides, pesticides (golf course, agricultural area)
☐	☐	☐		Use well water
☐	☐	☐		Live in new house
☐	☐	☐		House built prior to 1978
☐	☐	☐		Carpet in bedroom
☐	☐	☐		Pet dander
☐	☐	☐		Feather or down bedding

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing). – circle what applies

In order to improve your child's health, how willing are you /the child to do the following?:

Educate yourself about the child's conditions	5 4 3 2 1
Significantly modifying diet	5 4 3 2 1
Taking several nutritional supplements each day	5 4 3 2 1
Modifying lifestyle (e.g., work demands, sleep habits)	5 4 3 2 1
Practicing a relaxation technique	5 4 3 2 1
Engaging in regular exercise	5 4 3 2 1
Have periodic lab tests to assess progress	5 4 3 2 1
See other specialists (therapists, acupuncture)	5 4 3 2 1

Comments_____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? Rate on a scale of: 5 (very supportive) to 1 (very unsupportive) 5 4 3 2 1

Comments_____

** Please include age/year of onset in space next to condition **

Medical History: Illnesses/Conditions

Check YES = a condition you currently have, **Check PAST** = a condition you've had in the past.

Gastrointestinal	Yes	Past
Irritable bowel syndrome	☐	☐
GERD (reflux)	☐	☐
Crohn's disease/ulcerative colitis	☐	☐
Peptic ulcer disease	☐	☐
Celiac disease	☐	☐
Gallstones	☐	☐
Other:	☐	☐
Respiratory		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Sinusitis	☐	☐
Sleep apnea	☐	☐
Other:	☐	☐
Urinary/Genital		
Kidney stones	☐	☐
Gout	☐	☐
Interstitial cystitis	☐	☐
Frequent yeast infections	☐	☐
Frequent urinary tract infections	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted diseases	☐	☐
Other:	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Hypothyroidism (low thyroid)	☐	☐
Hyperthyroidism (overactive thyroid)	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Infertility	☐	☐
Metabolic syndrome/insulin resistance	☐	☐
Eating disorder	☐	☐
Hypoglycemia	☐	☐
Other:	☐	☐
Inflammatory/Immune		
Rheumatoid arthritis	☐	☐
Chronic fatigue syndrome	☐	☐
Food allergies	☐	☐
Environmental allergies	☐	☐
Multiple chemical sensitivities	☐	☐
Autoimmune disease	☐	☐
Immune deficiency	☐	☐
Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

Musculoskeletal	Yes	Past
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic pain	☐	☐
Other:	☐	☐
Skin		
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin cancer	☐	☐
Other:	☐	☐
Cardiovascular		
Angina	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
High blood fats (cholesterol, triglycerides)	☐	☐
Rheumatic fever	☐	☐
Arrythmia (irregular heart rate)	☐	☐
Murmur	☐	☐
Mitral valve prolapse	☐	☐
Other:	☐	☐
Neurologic/Emotional		
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

**** If symptoms present longer than 6 months, please include age/year of onset in space next to condition ****

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	☐	☐	☐
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Early waking	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Night waking	☐	☐	☐
Nightmares	☐	☐	☐
Can't remember dreams	☐	☐	☐
Low body temperature	☐	☐	☐
Head, Eyes, and Ears			
Conjunctivitis	☐	☐	☐
Distorted sense of smell	☐	☐	☐
Distorted taste	☐	☐	☐
Ear fullness	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye crusting	☐	☐	☐
Eye pain	☐	☐	☐
Eyelid margin redness	☐	☐	☐
Headache	☐	☐	☐
Hearing loss	☐	☐	☐
Hearing problems	☐	☐	☐
Migraine	☐	☐	☐
Sensitivity to loud noises	☐	☐	☐
Vision problems	☐	☐	☐
Musculoskeletal			
Back muscle spasm	☐	☐	☐
Calf cramps	☐	☐	☐
Chest tightness	☐	☐	☐
Foot cramps	☐	☐	☐
Joint deformity	☐	☐	☐
Joint pain	☐	☐	☐
Joint redness	☐	☐	☐
Joint stiffness	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle spasms	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscle twitches:	☐	☐	☐
Around eyes	☐	☐	☐
Arms or legs	☐	☐	☐
Muscle weakness	☐	☐	☐

Musculoskeletal *(cont.)*	Mild	Moderate	Severe
Neck muscle spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ problems	☐	☐	☐
Mood/Nerves			
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Auditory hallucinations	☐	☐	☐
Blackouts	☐	☐	☐
Depression	☐	☐	☐
Difficulty:	☐	☐	☐
Concentrating	☐	☐	☐
With balance	☐	☐	☐
With thinking	☐	☐	☐
With judgment	☐	☐	☐
With speech	☐	☐	☐
With memory	☐	☐	☐
Dizziness (spinning)	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Irritability	☐	☐	☐
Light-headedness	☐	☐	☐
Numbness	☐	☐	☐
Other phobias	☐	☐	☐
Panic attacks	☐	☐	☐
Paranoia	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tingling	☐	☐	☐
Tremor/trembling	☐	☐	☐
Visual hallucinations	☐	☐	☐
Cardiovascular			
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
High blood pressure	☐	☐	☐
Irregular pulse	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Phlebitis	☐	☐	☐
Swollen ankles/feet	☐	☐	☐
Varicose veins	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Urinary	Mild	Moderate	Severe
Bed wetting	☐	☐	☐
Hesitancy	☐	☐	☐
Infection	☐	☐	☐
Kidney disease	☐	☐	☐
Kidney stone	☐	☐	☐
Leaking/incontinence	☐	☐	☐
Pain/burning	☐	☐	☐
Prostate enlargement	☐	☐	☐
Prostate infection	☐	☐	☐
Urgency	☐	☐	☐
Digestion			
Anal spasms	☐	☐	☐
Bad teeth	☐	☐	☐
Bleeding gums	☐	☐	☐
Bloating of:	☐	☐	☐
Lower abdomen	☐	☐	☐
Whole abdomen	☐	☐	☐
Bloating after meals	☐	☐	☐
Blood in stools	☐	☐	☐
Burping	☐	☐	☐
Canker sores	☐	☐	☐
Cold sores	☐	☐	☐
Constipation	☐	☐	☐
Cracking at corner of lips	☐	☐	☐
Dentures w/poor chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Farting	☐	☐	☐
Fissures	☐	☐	☐
Foods "repeat" (reflux)	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Intolerance to:	☐	☐	☐
Lactose	☐	☐	☐
All dairy products	☐	☐	☐
Gluten (wheat)	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty foods	☐	☐	☐
Yeast	☐	☐	☐
Liver disease/jaundice	☐	☐	☐
(yellow eyes or skin)			

Digestion *(cont.)*	Mild	Moderate	Severe
Lower abdominal pain			
Mucus in stools			
Nausea	☐	☐	☐
Periodontal disease	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Vomiting	☐	☐	☐
Eating			
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't gain weight	☐	☐	☐
Can't lose weight	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Carbohydrate intolerance	☐	☐	☐
Poor appetite	☐	☐	☐
Salt cravings	☐	☐	☐
Frequent dieting	☐	☐	☐
Sweet cravings	☐	☐	☐
Caffeine dependency	☐	☐	☐
Respiratory			
Bad breath	☐	☐	☐
Bad odor in nose	☐	☐	☐
Cough – dry	☐	☐	☐
Cough – productive	☐	☐	☐
Hayfever:	☐	☐	☐
Spring	☐	☐	☐
Summer	☐	☐	☐
Fall	☐	☐	☐
Change of season	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus fullness	☐	☐	☐
Sinus infection	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Nails	Mild	Moderate	Severe
Bitten	☐	☐	☐
Brittle	☐	☐	☐
Curve up	☐	☐	☐
Frayed	☐	☐	☐
Fungus – fingers	☐	☐	☐
Fungus – toes	☐	☐	☐
Pitting	☐	☐	☐
Ragged cuticles	☐	☐	☐
Ridges	☐	☐	☐
Soft	☐	☐	☐
Thickening of:	☐	☐	☐
Finger nails	☐	☐	☐
Toenails	☐	☐	☐
White spots/lines	☐	☐	☐
Lymph Nodes			
Enlarged/neck	☐	☐	☐
Tender/neck	☐	☐	☐
Other enlarged/tender	☐	☐	☐
lymph nodes			
Skin, Dryness of			
Eyes	☐	☐	☐
Feet	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Hair	☐	☐	☐
And unmanageable?	☐	☐	☐
Hands	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Mouth/throat	☐	☐	☐
Scalp	☐	☐	☐
Any dandruff?	☐	☐	☐
Skin in general	☐	☐	☐
Skin Problems			
Acne on back	☐	☐	☐
Acne on chest	☐	☐	☐
Acne on face	☐	☐	☐
Acne on shoulders	☐	☐	☐
Athlete's foot	☐	☐	☐
Bumps on back of upper arms	☐	☐	☐
Cellulite	☐	☐	☐
Dark circles under eyes	☐	☐	☐
Ears get red	☐	☐	☐

Skin Problems *(cont.)*	Mild	Moderate	Severe
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Herpes – genital	☐	☐	☐
Hives	☐	☐	☐
Jock itch	☐	☐	☐
Lackluster skin	☐	☐	☐
Moles w color/size change	☐	☐	☐
Oily skin	☐	☐	☐
Pale skin	☐	☐	☐
Patchy dullness	☐	☐	☐
Psoriasis	☐	☐	☐
Rash	☐	☐	☐
Red face	☐	☐	☐
Sensitive to bites	☐	☐	☐
Sensitive to poison ivy/oak	☐	☐	☐
Shingles	☐	☐	☐
Skin cancer	☐	☐	☐
Skin darkening	☐	☐	☐
Strong body odor	☐	☐	☐
Thick calluses	☐	☐	☐
Vitiligo	☐	☐	☐
Itching Skin			
Anus	☐	☐	☐
Arms	☐	☐	☐
Ear canals	☐	☐	☐
Eyes	☐	☐	☐
Feet	☐	☐	☐
Hands	☐	☐	☐
Legs	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Genitals	☐	☐	☐
Roof of mouth	☐	☐	☐
Scalp	☐	☐	☐
Skin in general	☐	☐	☐
Throat	☐	☐	☐
Male Reproductive			
Discharge from penis	☐	☐	☐
Ejaculation problem	☐	☐	☐
Genital pain	☐	☐	☐
Impotence	☐	☐	☐
Infection	☐	☐	☐
Lumps in testicles	☐	☐	☐
Poor libido (low sex drive)	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive	Mild	Moderate	Severe
Breast cysts	☐	☐	☐
Breast lumps	☐	☐	☐
Breast tenderness	☐	☐	☐
Ovarian cyst	☐	☐	☐
Poor libido (sex drive)	☐	☐	☐
Endometriosis	☐	☐	☐
Fibroids	☐	☐	☐
Infertility	☐	☐	☐
Vaginal discharge	☐	☐	☐
Vaginal odor	☐	☐	☐
Vaginal itch	☐	☐	☐
Vaginal pain	☐	☐	☐
Premenstrual:	☐	☐	☐
Bloating	☐	☐	☐
Breast tenderness	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Chocolate craving	☐	☐	☐
Constipation	☐	☐	☐
Decreased sleep	☐	☐	☐
Diarrhea	☐	☐	☐
Fatigue	☐	☐	☐
Increased sleep	☐	☐	☐
Irritability	☐	☐	☐
Menstrual:	☐	☐	☐
Cramps	☐	☐	☐
Heavy periods	☐	☐	☐
Irregular periods	☐	☐	☐
No periods	☐	☐	☐
Scanty periods	☐	☐	☐
Spotting between	☐	☐	☐

Atma
REDISCOVER YOUR HEALTH

FOOD JOURNAL

NAME: _____

DOB: _____

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it. At the bottom please record all bowel movements along with stool type.

DATE:	Beverages	Environment	Mood/Digestive Changes
Breakfast (Time:_____)			
Snack (Time:_____)			
Lunch (Time:_____)			
Snack (Time:_____)			
Dinner (Time:_____)			
Snack (Time:_____)			

Bowel Movements (Time and Type)

Atma
REDISCOVER YOUR HEALTH

FOOD JOURNAL

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Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it. At the bottom please record all bowel movements along with stool type.

DATE:	Beverages	Environment	Mood/Digestive Changes
Breakfast (Time:_____)			
Snack (Time:_____)			
Lunch (Time:_____)			
Snack (Time:_____)			
Dinner (Time:_____)			
Snack (Time:_____)			

Bowel Movements (Time and Type)

Atma
REDISCOVER YOUR HEALTH

FOOD JOURNAL

NAME: _____

DOB: _____

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it. At the bottom please record all bowel movements along with stool type.

DATE:	Beverages	Environment	Mood/Digestive Changes
Breakfast (Time:_____)			
Snack (Time:_____)			
Lunch (Time:_____)			
Snack (Time:_____)			
Dinner (Time:_____)			
Snack (Time:_____)			

Bowel Movements (Time and Type)

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0 – ***Never or almost never*** have the symptom
1 – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total _____

NUTRITIONAL THERAPY
INFORMED CONSENT AND DISCLAIMER

Before you choose to use the services of a Nutritional Therapist, please read the following information **FULLY AND CAREFULLY.**

GOAL: Our basic goal is to encourage people to become knowledgeable about and responsible for their own health, and to bring it to a personal optimum level. Nutritional therapy is designed to improve your health, but is not designed to treat any specific disease or medical condition. Reaching the goal of optimum health, absent other non-nutritional complicating factors, requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A Nutritional Therapist is trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements. A Nutritional Therapist is not trained to provide medical diagnoses, and no comment or recommendation should be construed as being a medical diagnosis. Since every human being is unique, we cannot guarantee any specific result from our programs.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. A Nutritional Therapist is not a substitute for your family physician or other appropriate healthcare provider. A Nutritional Therapist is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases.

If you are under the care of another healthcare provider, it is important that you contact your other healthcare providers and alert them to your use of nutritional supplements. Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program.

If you are using medications of any kind, you are required to alert the Nutritional Therapist to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist.

If you have any physical or emotional reaction to nutritional therapy, discontinue their use immediately, and contact your Nutritional Therapist to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy.

COMMUNICATION: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to do your part by using your nutrition guidelines, exercise your body and mind sufficiently to bring your emotions into a positive balance, eat a proper diet, get plenty of rest, and learn about nutrition. You must stay in contact with the Nutritional Therapist so we can let you know what is happening and the best course of action.

You should request your other healthcare provider, if any, to feel free to contact the Nutritional Therapist for answers to any questions they may have regarding nutritional therapy.

LICENSURE: A Nutritional Therapist is not licensed or certified by any state. However, a Nutritional Therapy Practitioner™ is trained by the Nutritional Therapy Association, Inc.® which provides a certificate of completion to students who have successfully met all course requirements, including a written and practical exam. A license to practice Nutritional Therapy is not required in some states. Laws and regulations regarding certification and licensure requirements differ from state to state.

FEES: This coaching agreement is valid as of date of signing. Client agrees to pay all fees at time of visit. Fees are per visit, in accordance with fee schedule. The fee schedule is subject to change upon notice from Atma Clinic to Client.

CANCELLATION POLICY: Client agrees that it is the Client's responsibility to notify the Nutrition Therapist 24 hours in advance of the scheduled calls/meetings. Nutrition Therapist reserves the right to bill Client for a missed meeting. Nutrition Therapist will attempt in good faith to reschedule the missed meeting.

By my/our signature(s) below, I/we acknowledge and agree that the Nutritional Therapist is not responsible for any resulting sickness or ailment from any dietary change and/or consuming nutritional supplements. I/we fully understand and accept the risks associated with implementing new dietary changes and consuming nutritional supplements. I/we understand and agree on behalf of myself, my dependents, heirs, administrators, legal representatives, and assigns, to release and hold harmless the Nutritional Therapist, Atma Clinic, LLC and any and all members, employees, agents and representatives thereof, from any and all liability for illness, injuries, or death, and for any losses or damages relating thereto, however occurring, in relation to my use of the services of the Nutritional Therapist. Without limitation, I understand and agree that neither the Nutritional Therapist, Atma Clinic, LLC, nor any members, employees, agents or representatives thereof, is liable for any direct, indirect, consequential, or incidental damage, injury, death, loss, delay, or inconvenience of any kind which may be occasioned by reason of any act or omission, including, without limitation, any willful or negligent act or failure to act, or breach of contract. I/we confirm that I/we have read and fully understand the above disclaimer and waiver of liability are in complete agreement thereto and do freely and without duress sign and consent to all terms contained herein.

CLIENT NAME (PLEASE PRINT) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (HOME) _____ (WORK) _____ (OTHER) _____

SIGNATURE _____ DATE _____

SIGNATURE FOR CLIENT _____

RELATIONSHIP TO CLIENT _____ DATE _____

NUTRITIONAL THERAPY MAY NOT BE COVERED BY INSURANCE AND ALL COSTS ARE THE SOLE RESPONSIBILITY OF THE CLIENT.

Notification of Federal Health Care Privacy Rights

Please sign below indicating you have received this is notification of your Federal Health Care Privacy Rights:

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance portability and Accessibility Act (HIPAA), Atma Clinic can use your protected health information for treatment, payment and health care operations.

1. Treatment – we may use or disclose your health information to a physician or other health care provider providing treatment to you.

2. Payment – we may use and disclose your health information to obtain payment for services we provide you.

3. Healthcare Operations – we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Most uses and disclosures that do not fall under treatment, payment, healthcare operations will require your written authorization. Upon signing, you may revoke your authorization in writing through our practice at anytime.

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or other person responsible for your care, using your professional judgment. We will only disclose health information that is directly relevant to the person's involvement with your healthcare.

We will not use your health information for marketing communications without your written consent.

We may also use or disclose your health information when we are required to do so by law.

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health and safety.

We may disclose the health information of armed forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may

disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

We may use or disclose your health information to provide you with appointment reminders via phone, email or letter.

You have the right to restrict the disclosure of your protected health information in writing. The request for restriction may be denied if the information is required for treatment, payment or healthcare operations.

You have the right to
- Receive confidential communications regarding your protected health information.
- Inspect a copy of your protected health information.
- Amend your protected health information.
- Receive an account of disclosures of your protected health information.
- A paper copy of this notice of privacy practices.

If you have any complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

For further information about Atma Clinic's privacy policies, please contact our office and at the following address or phone number:
1026 Westdale Rd
Lawrence, KS 66049
(785) 760-0695

Printed Name

_____

Signature

_____

Date

_____

An Integrative approach to Personalized Medicine

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ Date of Birth _____
Address_____
City, ST, Zip _____ Phone _____

I authorize to release medical records:

From: Dr's Name/Facility Name _____
Address _____
City, ST, Zip _____
Phone _____ Fax _____

To: Atma Clinic
1011 Westdale Rd
Lawrence, KS 66049
Ph: 785-760-0695 Fax: 855-892-4307

I authorize the disclosure of the following:

( ) Progress Notes ( ) Lab
( ) Radiology and Imaging reports ( ) Immunizations
( ) Entire records ( ) Records from (date) _____ to _____
( ) Other _____

Purpose of Transfer _____

- I understand that the information in my health record may include that relation to alcohol or drug abuse, abortion, acquired immune deficiency syndrome (AIDS), developmental disabilities, human immunodeficiency virus (HIV), behavioral or mental health services, or sexually transmitted infection.
- I understand that I have the right to inspect or copy the information I have authorized to be used or disclosed by tis form.
- I understand that if the parties listed above are not health care providers, health plans or health care clearinghouses who must follow the federal standards and may be redisclosed without obtaining my authorization.
- I understand that I have the right to revoke this authorization at any time. Such revocation must be in writing and presented to address above. Such revocation will not apply to information that has already been released per this authorization.
- I understand that authorizing the disclosure of this information is voluntary. Refusing to sign this authorization will not affect my receiving treatment. It is expressly agreed that a photocopy of this authorization is as valid as the original

Signature of Patient or Legal Guardian _____
Today's Date _____ Expiration Date_____