Welcome

We would like to learn more about you and your health so that we can give you the best care possible. Please help us by filling this form accurately and concisely.

First Name ______________________ M.I. _____ Last Name ________________________

How should we refer to you? (Nickname) ____________________ SS# _______________

Address __________________________ City _______________________ Zip __________

E-mail ______________________________ D.O.B. _____________________ Age _______

Phone # (H) ________________(W) ___________________ (C) ______________________

How did you find out about our office?_____________ If referred, by who ____________

FAMILY

Married? __________ # of Children? __________

Names of children still living at home ____

Do your children have any health concerns or conditions? If so, please list

____

Spouse or Significant other's name ____

Do they have any health concerns or conditions? If so, please list

____

Quality of your family relationship? (Check one) [ ] Great [ ] Okay [ ] Dissatisfied

Are there any health conditions in your family that you may have possibly inherited? If so please list ____

YOUR LIFESTLYE HISTORY

1. Reasons for seeking services at our office?_____________________________________

2. Are you seeking [ ] Wellness care [ ] Injury care [ ] Family Wellness Care

3. If you have an injury, please describe ____

4. How long have you been experiencing this problem? ________ Date of onset ________

5. Rate the intensity of the problem (circle one): 0= no problem, 10- terrible/unbearable

0 1 2 3 4 5 6 7 8 9 10

6. Have you received Chiropractic care in the past? Yes / No

7. If so, when was your last adjustment?_______ How long were you under care?______

8. Do you feel that it helped you? Yes / No Were you under maintenance care? Yes / No

9. Were X-rays taken? Yes/ No If so, date taken _______ Can you get a copy? Yes / No

10. Have you ever had surgery? If so, please explain:

____

11. Is there anything about your nervous system or spine that we should know about?

____

12. Your history of conditions (ie.Aids, Cancer, Hepatitis, Stroke, Heart Disease, COPD,

etc)____

11. Do you have any digestive issues? (Acid Reflux, Constipation, Hyadel Hernia,

Inflammatory bowel issues, etc) ____

12. Are you taking any prescriptions? (Prescribed or over the counter.)

____

13. History of physical stress, trauma, or challenges (i.e. Falls, Auto Accidents)

____

14. Occupation ________________________ **Employer** ________________________________

15. If retired please list your prior occupation -_______________________________________

16. Satisfaction with career? (Check one) [ ] Great [ ] Okay [ ]Dissatisfied

17. Please list history of emotional stress____

18. Current mental and emotional stress level [ ] Minimal [ ] Moderate [ ] Severe

19. What do you do for fun and/or relaxation? _____________________________________

20. How often and what kind of exercise do you do? Are you a member of a health club?

____

21. How many glasses of water you drink a day? ___________________________________

22. What else do you drink for fluid intake?_______________________________________

23. How many hours of sleep do you get per night __________________________________

24. Quality of your sleep? [ ] Great [ ] Okay [ ] Poor

25. Do you believe in preventative health care? ___________________________________

26. What is your level of commitment to yourself, your life, and your well-being?

[ ] Low [ ] Medium [ ] High

27. How is LIFE?____

28. Emergency contact information____

HIPAA LAW #101-191 CONSENT
This office is HIPAA compliant. Your records are kept in the strictest confidence, however it may be necessary to diclose information to another health care provider as well as to other third party payers if they are responsible for payment of your services. It may be necessary to use or disclose information within our practice for quality control and operational purposes. (ie: appointment reminders at home or work, leaving massages on answering machine, leaving messages with a person, testimonials of your improvement in written or verbal form, family picture boards, sending you newsletters, and sending you thank you gifts as well as open adjusting areas). You have the right to request a more detailed "Notice of Privacy for Private Health Information" upon request at any time during your care. If any changes occur in reference to our privacy practices you will be notified by posting of the change in the office. By signing below you accept and give us permission to disclose this information. You have the right to not disclose any of this information however requests must be in writing.

Assignment of Benefits:
I herby irrevocably instruct and direct my Insurance Company to pay Drs. Evans Inc. directly. For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I also authorize the release of any information pertinent to my case to any insurance company, Health Care Financing Administration or its agents, or attorney involved in this case. I authorize doctor initiate a complaint to the Insurance Commissioner for any reason on my behalf. In addition, I authorize Drs. Evans to deposit any checks received on my account when made out to me.

I understand all the information on this form and I answered it true and correct to the best of my ability:

_______________________________ ____

Signature Print Date