Evolve
Health & Wellness Centers

PATIENT INFORMATION

Patient Name________________________________ Date of Birth ____/____/________

Home Address: ______________________________ ____________________ __________ __________
STREET ADDRESS OR POST OFFICE BOX CITY STATE ZIP CODE

Home Phone ________________________ Cell ______________ Gender Male or Female

S.S. # _______________________ Age ________ Email _______________________

Circle One: Minor Single Married Divorced Widowed Separated

Employer ___________________________________ Occupation ____________________

Work phone _______________________ Spouse name __________________________________

Emergency Contact____

Pharmacy Name: ____

Pharmacy Phone Number: ____

Are you pregnant: YES NO Due Date: ______________________

REVIEW OF SYSTEMS:

Symptoms Experienced Following Accident/Injury

- ❑ *General Fatigue*
- ❑ *Anxiety*
- ❑ *Dizziness*
- ❑ *Depression*
- ❑ *Fainting*
- ❑ *Loss of Sleep*
- ❑ *Inability to Urinate*
- ❑ *Skin itching/dryness*
- ❑ *Nose/Sinus Pain*
- ❑ *Hearing trouble right side*
- ❑ *Painful menstruation*
- ❑ *Chronic Nasal Infection*
- ❑ *Chronic cough*
- ❑ *Chest Pain or Disturbances*
- ❑ *Chronic wheezing*
- ❑ *Difficult Breathing*
- ❑ *Abdominal Pain*
- ❑ *Difficulty Urinating*
- ❑ *Swollen Extremities*
- ❑ *Excess Gas*
- ❑ *Hearing trouble left side*
- ❑ *Vision Trouble*
- ❑ *Vomiting (excessive)*
- ❑ Diarrhea (excessive)
- ❑ Skin Rash
- ❑ *Constipation (excessive)*
- ❑ *Brusiing*
- ❑ *Heartburn/indigestion*
- ❑ *Memory Loss*
- ❑ *Weight change*
- ❑ *Irregular Menstruation*
- ❑ *Eczema*
- ❑ *Sexual Discomfort*

Mark YES or NO to indicate if you have had or currently have any of the following:

AIDS/HIV	Y	N	Goiter	Y	N	Parkinson's Disease	Y	N
Alcoholism	Y	N	Gonorrhea	Y	N	Pinched Nerve	Y	N
Allergy Shots	Y	N	Gout	Y	N	Pneumonia	Y	N
Anemia	Y	N	Heart Disease	Y	N	Polio	Y	N
Anorexia	Y	N	Hepatitis	Y	N	Prostate Problem	Y	N
Appendicitis	Y	N	Hernia	Y	N	Prosthesis	Y	N
Arthritis	Y	N	Herniated Disc	Y	N	Psychiatric Care	Y	N
Asthma	Y	N	Herpes	Y	N	Rheumatoid Arthrosis	Y	N
Bleeding Disorder	Y	N	High Blood Pressure	Y	N	Rheumatic Fever	Y	N
Breast Lump	Y	N	High Cholesterol	Y	N	Scarlet Fever	Y	N
Bronchitis	Y	N	Kidney Disease	Y	N	STD	Y	N
Bulimia	Y	N	Liver Disease	Y	N	Stroke	Y	N
Cancer	Y	N	Measles	Y	N	Suicide Attempt	Y	N
Cataracts	Y	N	Migraine Headaches	Y	N	Thyroid Problems	Y	N
Chemical Dependency	Y	N	Miscarriage	Y	N	Tonsillitis	Y	N
Chicken Pox	Y	N	Mononucleosis	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Multiple Sclerosis	Y	N	Tumors, Growths	Y	N
Emphysema	Y	N	Mumps	Y	N	Typhoid Fever	Y	N
Epilepsy	Y	N	Osteoporosis	Y	N	Ulcers	Y	N
Fracture	Y	N	Pacemaker	Y	N	Vaginal Infections	Y	N
Glaucoma	Y	N				Whooping Cough	Y	N
						Other:		

HABITS/ACTIVITIES:

Smoking (packs per day)-	Never <1	1-2	2-3	3-4	5+	
Caffeinated Drinks (glasses per day)-	Never <1	1-2	2-3	3-4	5+	
Alcohol Consumption (glasses per day)-	Never <1	1-2	2-3	3-4	5+	
Drug/Substance Abuse-	Yes	No				
Exercise-	Never <1	1-2	2-3	3-4	5+	
Type of Exercise:	Walking	Jogging	Cycling	Swimming	Gyms	Weights

MEDICAL HISTORY:

Please list any vitamins or other supplements you are currently taking: ______________________________

____

Have you have been hospitalized in the past?

Date and reason for hospitalization: ______________________________________

Have you had any previous surgeries/accidents? ____________________________

If so, please describe: ____

Do you have a family physician Yes No Date of last exam: ________________

Name, Phone, Address: ____

____

Please list all medications you are currently taking and the conditions they are treating: ________________

____

Are you allergic to any medications? Yes No If yes please list.

____

ATTORNEY INFORMATION

Name: ______________________________ Phone Number: ______________________

Address: ______________________________ ____________________ __________ __________
STREET ADDRESS OR POST OFFICE BOX CITY STATE ZIP CODE

INSURANCE COMPANY INFORMATION

Name: ______________________________ Phone Number: ______________ Claim Number: ____________

Address: ______________________________ ____________________ __________ __________
STREET ADDRESS OR POST OFFICE BOX CITY STATE ZIP CODE

INJURY INFORMATION

Date of Injury: ______________ Time of Injury: ________ ❑ *A.M.* ❑ *P.M.* On-the-Job Injury ❑ *Yes* ❑ *No*

AUTOMOBILE INJURY INFORMATION (FILL OUT THIS SECTION ONLY IF INJURY WAS FROM AUTO ACCIDENT)

Patient's car was going (direction): __________________________

Patient's car was: ❑ *Moving* ❑ *Stopped* ❑ *Turning Left* ❑ *Turning Right*

Car hit/was hit in the: ❑ *Front* ❑ *Rear* ❑ *Left Side* ❑ *Right Side*

Did you see the accident coming? ❑ *Yes* ❑ *No* Were you wearing a seat belt? ❑ *Yes* ❑ *No*

Upon impact - what direction was your body thrown? ❑ Forward ❑ Backward ❑ Left ❑ Right

- was there a "binding" or "explosive" sensation in your head? ❑ Yes ❑ No

Which areas of your body hurt immediately after the accident: ______________________________

____

Were you able to get out of the car and walk? ❑ *Yes* ❑ *No* *Were you* conscious at all times? ❑ *Yes* ❑ *No*

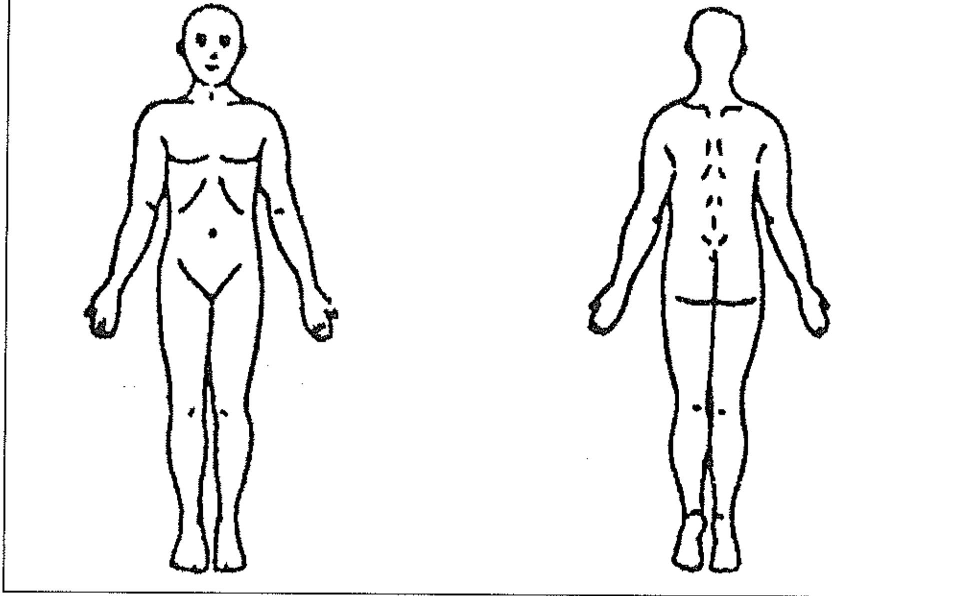
Were you able to move all parts of your body? ❑ *Yes* ❑ *No*

Was an ambulance called? ❑ *Yes* ❑ *No* Did you go to the hospital? ❑ *Yes* ❑ *No*

If so, what was done? ❑ *X-Rays* ❑ *Examination* ❑ Medications (nature): ______________________

Length of time in hospital: ___________ Admitted (date): ______________ Released (date): ______________

Please mark your areas of pain on the figures below.
Use a 1 to 10 scale, with 1 being little pain and 10 being the worst possible pain.



Please explain any of the above symptoms: ______________________________

____

____

Please list and explain any other symptoms you are experiencing: ______________________

____

____

OTHER INJURY INFORMATION

How did the injury happen? ______________________________

____

____

______________________________ Patient Signature

__________ Date Signed

Restrictions of the Activities of Daily Living (ADL)

Please check each question that applies

(1) HEALTH CARE:

Are you experiencing:	Difficulty or Pain	Unable to Perform
Bathing	YES( )	YES( )
Getting into or out of the bathtub	YES( )	YES( )
Getting on or off the toilet	YES( )	YES( )
Washing or shampooing your hair	YES( )	YES( )
Grooming your hair	YES( )	YES( )
Putting on your pantyhose	YES( )	YES( )
Putting on or taking off your shoes	YES( )	YES( )
Putting on a bra	YES( )	YES( )
Applying body lotion or suntan lotion	YES( )	YES( )
Brushing your teeth	YES( )	YES( )

(2) ACTIVITIES INVOLVING POSTURE:

Are you experiencing:	Difficulty to or Pain	Unable Perform
With prolonged standing	YES( )	YES( )
With prolonged sitting	YES( )	YES( )
With prolonged walking	YES( )	YES( )
Stair climbing	YES( )	YES( )
Crawling	YES( )	YES( )
Stooping	YES( )	YES( )
Bending	YES( )	YES( )
Laying on your stomach	YES( )	YES( )
Laying on your back	YES( )	YES( )
Kneeling	YES( )	YES( )
Squatting	YES( )	YES( )

(3) TRAVEL DRIVING ABILITIES

Are you experiencing:	Difficulty to or Pain	Unable Perform
Turning your head while backing up	YES( )	YES( )
Rotating your body while backing up	YES( )	YES( )
Prolonged sitting as a driver/passenger	YES( )	YES( )
When driving on a bumpy road.	YES( )	YES( )

(4) SLEEP HABITS

Are you experiencing:	Difficulty to or Pain	Unable Perform
Do you take longer to fall asleep	YES( )	YES( )
Interrupted due to pain	YES( )	YES( )
Are you awakened early due to pain	YES( )	YES( )
You cannot fall asleep without medication	YES( )	YES( )

(5) HOUSEHOLD RESPONSIBILITES

Are you experiencing:	Difficulty or Pain	Unable to Perform
Scrubbing the tub	YES ( )	YES( )
Scrubbing floors	YES( )	YES( )
Vacuuming	YES ( )	YES( )
Sweeping	YES( )	YES( )
Taking outthe trash	YES( )	YES( )
Standing while washing dishes	YES( )	YES( )
Preparing mealsorcooking	YES( )	YES( )
Canying groceries	YES( )	YES( )
Putting away groceries	YES( )	YES( )
Carrying a laundry basket	YES( )	YES( )
Doing the laundry	YES( )	YES( )
Gardening	YES( )	YES( )
Washing the car	YES( )	YES( )

(6) SEXUAL FUNCTIONS

Are you experiencing:	Difficulty to Pain	Unable Perform
Participating in sexual activities	YES( )	YES( )

____
Patient Signature

____
Date

Functional Rating Index

For use with <u>Neck and/or Back Problems</u> only.

In order to properly assess your condition, we must understand how much your <u>neck and/or back problems</u> have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name ______________________________
PRINTED

Total Score __________

____
Signature

____
Date

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's name:________________________ Date of Birth: ______________________________
Social Security Number:____

I request and authorize **Evolve Health & Wellness Centers** to release healthcare information of the patient named above to the following **doctors/medical facilities/family members/attorney/other:**

Name: ____
Address:____
City:____________________ State:____________________ Zip Code:______________________

Name: ____
Address:____
City:____________________ State:____________________ Zip Code:______________________

Name: ____
Address:____
City:____________________ State:____________________ Zip Code:______________________

This request and authorization applies to

☐ All healthcare information

☐ Other: ____

____
Patient Signature Date Witness Date

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

- **Patient Name:** ______________________________
- **Date of Birth:** __________

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Evolve Health & Wellness Centers, LLC

I understand that the Notice describes the uses and disclosures of my protected health information by Evolve Health & Wellness Centers, LLC and informs me of my rights with respect to my protect health information.

X ______________________________
Patient's Signature of that of Legal Representative

X ______________________________
Printed Name of patient or that of Legal Representation

X ______________________________
If Legal Representative, indicate Relationship

X ____________________
Today's Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain acknowledgement.
- ☐ Communications barriers prohibited obtaining the acknowledgement.
- ☐ Other (please specify): ______________________________

X ______________________________
Employee Name

X ____________________
Today's Date

Billing and payment

In connection with your treatment payment is accepted the following ways. Please indicate your method of payment.

__________ **Third Party Fault:** If your injury was caused by a third party and you have a representing attorney, Evolve Health and Wellness Centers, LLC will contact your attorney for payment.

__________ **Self Pay:** If you have no available insurance coverage you will be billed for the services that has been provided.

__________ **Health Insurance:** We will bill your health insurance provider, if we are contracted with that insurance company. However, you are responsible for all co-payments or deducible payments per your insurance plan.

Patient's Name Printed: ____
(Last) (MI) (First)

Patient's Signature: ________________________ Date: ________________________

Patient's Representative (if minor): ____

Relationship to Patient: ____

ASSIGNMENT OF BENEFITS

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICE RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Evolve Health & Wellness Centers, LLC. and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and Evolve Health & Wellness Centers, LLC. which checks, drafts or money orders are made payable for services which have been made by Evolve Health & Wellness Centers, LLC., at the request of with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes but is not limited to, all rights to collect benefits directly from my insurance company for services that I have received and all rights to proceed against my insurance company in any action including legal suit if for any reason my insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the provider as my assignee.

The undersigned by these presents does give and grant Evolve Health & Wellness Centers, LLC. as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

At any time after Insurer fails to render the applicable payment within 30 days upon receipt of Health Care Providers medical bills got any date of service, this agreement may be revoked. Health Care Provider's said revocation will be effective on the thirty first (31) day after Insurer has received Health Care Provider medical bill(s) that Insurer has denied, withdrawn, reduced, or failed to pay. Said revocation shall include any and all dates of services subsequent to the thirty-first (31) day after Insurer has received Health Care Provider medical bills that Insurer has denied, withdrawn, reduced, or failed to pay.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do cause to be done by virtue of these presents.

______________________	______________________	__________
PATIENT'S SIGNATURE	PATIENT'S NAME	DATE

INFORMED CONSENT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. I understand that results are not guaranteed. My condition may or may not improve with chiropractic care. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

The information made on this form is accurate and I agree to allow this office to examine me for further evaluation:

Signature:______________________________ Date:______________