EVOLUTIONARY HEALING INSTITUTE

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NEW PATIENT INFORMATION

DATE _____

PATIENT NAME LAST _____ FIRST _____ MI _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX - M_____ F_____ AGE _____ BIRTH DATE _____ MINOR_____

MARRIED_____ WIDOWED_____ SINGLE_____ SEPARATED_____ DIVORCED_____ PARTNERED_____

OCCUPATION_____

PATIENT EMPLOYER/SCHOOL_____

EMPLOYER/SCHOOL ADDRESS_____

EMPLOYER/SCHOOL PHONE_____

SPOUSE/PARTNER NAME_____ BIRTH DATE_____

SPOUSE'S/PARTNER'S EMPLOYER_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

CONTACT INFORMATION

EMAIL_____ PRIMARY PHONE_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

BEST TIME AND PLACE TO REACH YOU_____

IN CASE OF EMERGENCY, CONTACT

NAME_____ RELATIONSHIP_____ PRIMARY PHONE_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

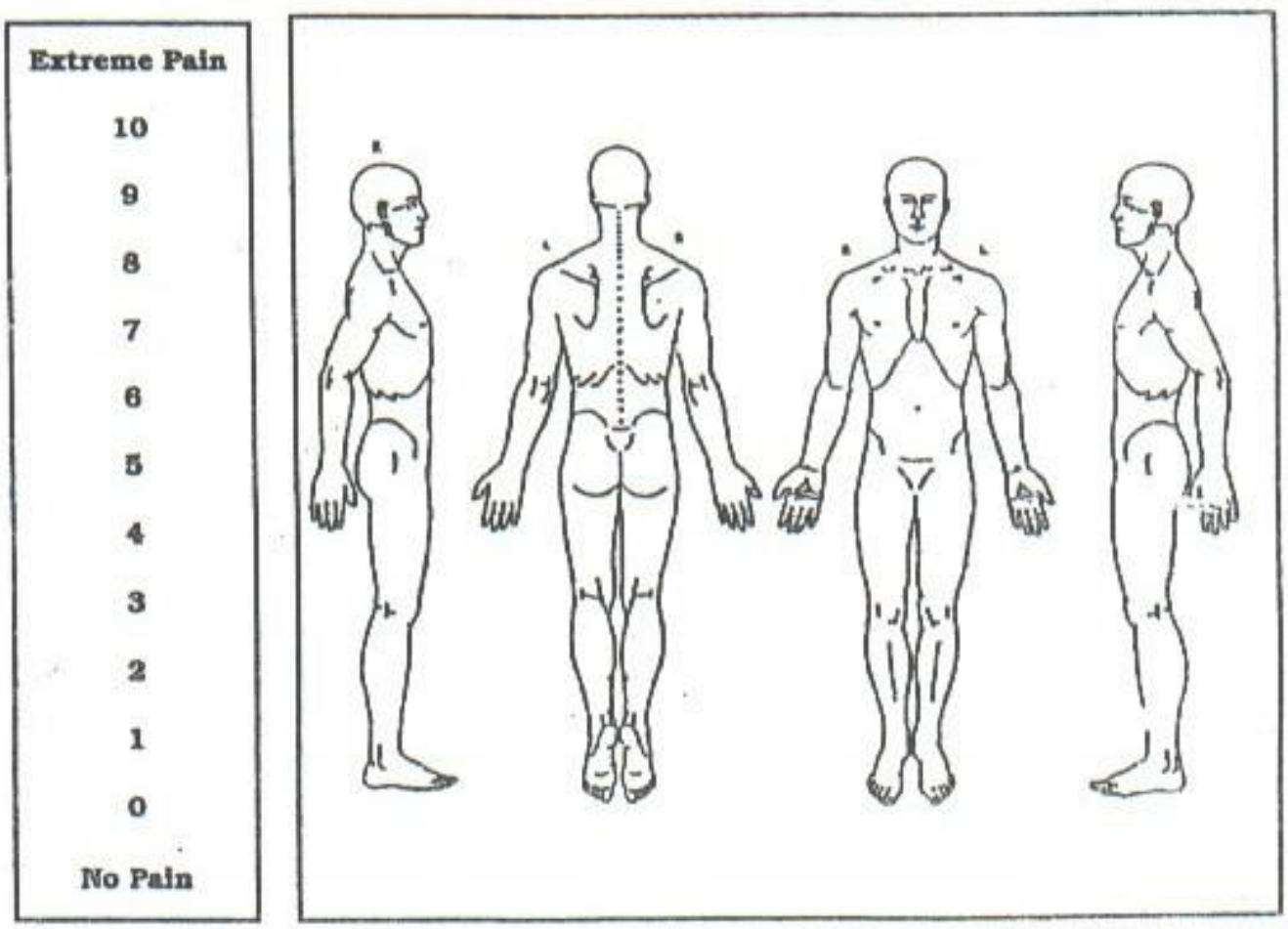
PATIENT CONDITION

Reason for visit_____

When did your symptoms first appear?_____

Mark on the picture below where you continue to have pain, numbing or tingling and rate the severity of your pain according to the scale below where 1 is least pain and 10 is severe pain.

For example – if you have severe pain in the back of your neck (2nd figure) place a "10" in that box.



TYPE OF PAIN

___ Sharp	___ Dull	___ Throbbing	___ Numbness
___ Aching	___ Shooting	___ Burning	___ Tingling
___ Cramps	___ Stiffness	___ Swelling	___ Other

How often do you have this pain?_____ Is it constant or does it come and go?_____

Is this condition getting progressively worse? ___Yes ___No ___Unknown

Does it interfere with your ___Work ___Sleep ___Daily Routine ___Recreation

Activities/movements that is painful to perform ___Sitting ___Standing ___Walking ___Bending ___Lying Down

What treatment have you already received for your treatment?

___Medications ___Surgery ___Physical Therapy ___Chiropractic ___None ___Other _____

Name and Address of other Doctor(s) who have treated you for your condition

_____

_____

DATE OF LAST

Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

HEALTH HISTORY

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	AIDS/HIV	___	___	Chicken Pox	___	___	Liver Disease	___	___	Rheumatoid Arthritis
___	___	Alcoholism	___	___	Diabetes	___	___	Measles	___	___	Rheumatic Fever
___	___	Allergy Shots	___	___	Emphysema	___	___	Migraines	___	___	Scarlet Fever
___	___	Anemia	___	___	Epilepsy	___	___	Miscarriage	___	___	Stroke
___	___	Anorexia	___	___	Fractures	___	___	Mononucleosis	___	___	Suicide Attempt
___	___	Appendicitis	___	___	Glaucoma	___	___	Multiple Sclerosis	___	___	Thyroid Problems
___	___	Arthritis	___	___	Goiter	___	___	Mumps	___	___	Tonsillitis
___	___	Asthma	___	___	Gonorrhea	___	___	Osteoporosis	___	___	Tuberculosis
___	___	Bleeding Disorders	___	___	Gout	___	___	Pacemaker	___	___	Tumors/Growths
___	___	Breast Lump	___	___	Heart Disease	___	___	Parkinson's Disease	___	___	Typhoid Fever
___	___	Bronchitis	___	___	Hepatitis	___	___	Pinched Nerve	___	___	Ulcers
___	___	Bulimia	___	___	Hernia	___	___	Pneumonia	___	___	Vaginal Infections
___	___	Cancer	___	___	Herniated Disk	___	___	Polio	___	___	Venereal Disease
___	___	Cataracts	___	___	Herpes	___	___	Prostate Problem	___	___	Whooping Cough
___	___	Chemical Dependency	___	___	High Cholesterol	___	___	Prosthesis	___	___	Other
			___	___	Kidney Disease	___	___	Psychiatric Care	_____		

ARE YOU PREGNANT? ___Yes ___No Due Date_____

INJURIES/SURGERIES YOU HAVE HAD	**DESCRIPTION**	**DATE**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

EXERCISE

___None
___Moderate
___Daily
___Heavy

WORK ACTIVITY

___Sitting
___Standing
___Light Labor
___Heavy Labor

HABITS

___Smoking Packs/Day_____
___Alcohol Drinks/Week_____
___Coffee/Caffeine Drinks Cups/Day_____
___High Stress Level Reason_____

MEDICATIONS

_____
_____
_____
_____
_____
_____

ALLERGIES

_____
_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____
_____

WHAT CHANGES WOULD YOU LIKE TO EXPERIENCE AS A RESULT OF UNIFIED THERAPY™?

Please save this form and email to ehmiami@gmail.com