Drs. Evans P.C. 1½ Crosswicks St., Bordentown, NJ 08505 (609) 298-4299 Patient#: _____

Welcome

We would like to learn more about you and your health so that we can give you the best care possible.

First Name: _____M.I._____ Last Name:_____ ____Nick Name _____

Address: _____ City: _____ State:____ Zip_____

Home Phone _____-_____-_____ Cell Phone:_____-_____-_____ Work Phone: _____-_____-_____

Gender: Male___ Female:___ DOB:___/___/___ Social Security Number:_____-_____-_____

Email: _____ Who Referred You? _____

Married? Y N if yes spouse name:_____ ___Children? Y N if yes ages:_____

Preferred Language: _____ Ethnicity: Hispanic/Latino__ Not Hispanic/Latino__ Decline__

Race: Native American/Alaskan__ Asian__ Black/African American__ Native Hawaiian__ Caucasian/White__ Decline__

Smoking Status: Current Daily__ Current Some Days__ Former Smoker__ Never Smoker__ Unknown__

Height:_____ Weight:_____ Blood Pressure:_____/_____ Heart Rate:_____ Respiration:_____ Temp:____

Have you ever been under Chiropractic care? Y / N If so, when was the last time you were adjusted? _____

YOUR LIFESTYLE HISTORY

List any **Allergies**:

☐ Animals	☐ Dairy	☐ Molds	☐ Seasonal Allergies	☐ Wheat
☐ Aspirin	☐ Dust	☐ Penicillin	☐ Shellfish	☐ X-Ray Dye
☐ Bees	☐ Eggs	☐ Ragweed/Pollen	☐ Soaps	☐ Medications
☐ Chocolate	☐ Latex	☐ Rubber	☐ Sulfur	☐ Other:_____

List any **Surgeries**:

☐ Back	☐ Foot	☐ Neck	☐ Wrist
☐ Brain	☐ Hip	☐ Neurological	☐ Other: _____
☐ Elbow	☐ Knee	☐ Shoulder	

List **ALL Past Medical History** conditions:

☐ Ankle Pain	☐ Diabetes	☐ Hand Pain	☐ Knee Pain	☐ Parkinson's
☐ Arm Pain	☐ Dizziness	☐ Headaches	☐ Leg Pain	☐ Polio
☐ Arthritis	☐ Elbow Pain	☐ Hearing Problems	☐ Menstrual Problems	☐ Prostate Problems
☐ Asthma	☐ Epilepsy	☐ Hepatitis	☐ Mid-Back Pain	☐ Shoulder Pain
☐ Back Pain	☐ Eye/Vision Problems	☐ High Blood Pressure	☐ Minor Heart Problem	☐ Significant Weight Change
☐ Broken Bones	☐ Fainting	☐ Hip Pain	☐ Multiple Sclerosis	☐ Spinal Cord Injury
☐ Cancer	☐ Fatigue	☐ HIV	☐ Neck Pain	☐ Sprain/Strain
☐ Chest Pain	☐ Foot Pain	☐ Jaw Pain	☐ Neurological Problems	☐ Stroke/Heart Attack
☐ Depression	☐ Genetic Spinal Condition	☐ Joint Stiffness	☐ Pacemaker	☐ Other:

Are you taking any **Medications**? Yes or No (circle)

Drug Name	Reason for Medication	Drug Name	Reason for Medication

List your **Family History**: Maternal Grandmother: High Blood pressure

Mother	Father	Sibling	Grandparents

Are your present problems due to an injury? □Yes □No □On Job □Auto Accident □Personal Injury □Other: _____

Has the accident been reported? □Yes □No □To Employer □Auto Carrier □Other: _____
Are you now or have you ever been disabled? (Service or Work)? □Yes □No When? _____
Have you retained an attorney? □Yes □No Name & Address:
_____

Have you had any auto or other accidents? □ No □Yes

Describe: _____

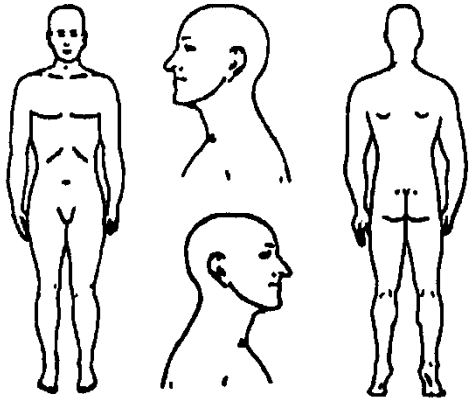
Date of last physical examination: _____ Do you smoke? □ No □Yes

Do you drink alcohol? □ No □Yes - how many per day? _____

Do you drink caffeine? □ No □Yes - how many per day? _____

Do you exercise? □ No □Yes (what forms and how often): _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Main reason for consulting the office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

#1

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____
How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING
Have you had this condition in the past? YES - NO
How often do you experience your symptoms?
□Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)
Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain
□Tightness □ Stabbing □ Throbbing □ Other: _____
Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)
□1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
What activities aggravate your condition (working, exercise, etc)? _____
What makes your pain better (ice, heat, massage, etc)? _____

#2

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐Constantly (76-100% of the day) □ Frequently (51-75% of the day)

☐Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

☐Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

#3

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐Constantly (76-100% of the day) □ Frequently (51-75% of the day)

☐Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

☐Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

#4

What is your major complaint? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?

☐Constantly (76-100% of the day) □ Frequently (51-75% of the day)

☐Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

Describe the nature of your symptoms: □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain

☐Tightness □ Stabbing □ Throbbing □ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

☐1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What activities aggravate your condition (working, exercise, etc)? _____

What makes your pain better (ice, heat, massage, etc)? _____

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.

___Records (Please Initial)
All your records are kept on file electronically. Because we do not have encryption to send them via email you can request a copy of your records at any time. Please let the doctor know if you would like a copy and they will be printed for you directly.

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

_____ _____ _____
Signature **Print** **Date**

I _____ am advised that Evans Family Chiropractors cannot accept assignment on my insurance company. Therefore, I am responsible to bring any insurance checks that I receive for my services rendered at Evans Family Chiropractors to them directly. If I do not bring in the checks I receive I know I will be held responsible for those services. If a check is not received at Evans Family Chiropractors within 30 days after the check was issued, the amount of the checks will be charged to my credit card.

Signature: _____ Date: _____

Family Member: _____ Date: _____

_____

Patient / Insured Information - Please Print

REQUIRED INFO	Patient		Insured	
Name				
Street				
City				
State & Zip				
Telephone #				
Date of Birth				
Relation To Insured: circle)	SELF	SPOUSE	CHILD	OTHER

REQUIRED INFO	Primary Insurance		Secondary Insurance	
Company Name				
Street				
City				
State & Zip				
Telephone #				
Policy #				
Group #				
I.D. #				
Auto Insurance	Auto Insurance		Attorney	
Insurance Co Name				
Claim #				
Adjustors Name				
Adjustors Phone #				

Have you experienced (or) are you currently experiencing any of the following:

Circle all that Apply

Name: _____

Constitutional Systems:

Chills Fatigue
Fever Poor appetite
Weight loss
Night sweats

Sleep:

Gasping Snoring
Insomnia Restless legs
Difficulty sleeping

Ears:

Hearing loss Ringing
Ear pain

Eyes:

Blurry vision Change in vision
Double vision Eye pain

Nose/Mouth &Throat:

Change of sense of smell Runny nose
Nose bleeding Sores in mouth
Sores in mouth Sore throat
Difficulty or pain swallowing

Cardiovascular:

Chest pain Palpitations
Swollen legs Fainting
Shortness of breath

Respiratory:

Cough Coughing up blood
Coughing up phlegm Wheezing

Gastrointestinal:

Abdominal pain Nausea
Diarrhea Vomiting
Constipation Heartburn

Musculoskeletal:

Muscle Pain Bone Pa
Joint Pain Swollen or red joints
Broken bones

Genitourinary:

Difficulty urinating Vaginal or penile discharge
Kidney stone

Skin:

Rash Ulcers that will not heal
Moles that are changing

Endocrine:

Heat or cold intolerance frequent urination
Unusually thirsty high / low blood sugar

Neurological:

Headaches Weakness
Seizure Dizziness
Tremor TIA's
Stroke

Lymph and Heme:

Easy bleeding Swollen lymph nodes

Psychiatric:

Depression Anxiety
Hallucinations

Signature:_____Date:_____

Covid-19 Health Waiver

I herby acknowledge that I am not experiencing the following conditions or if I do I will reschedule my appointment with Drs Evans P.C.

- Fever- I am responsible for taking my temperature
- New worsening or shortness of breath that is not due to another health problem
- Muscle aches and pain
- Sore throat
- Diarrhea
- Chills and shaking
- Fatigue (more than usual)
- Loss of taste or smell
- Nausea or vomiting
- Have tested positive for COVID in the last 14 days or have been in contact within the last 14 days with anyone positive for COVID
- I have not received the Flu or COVID vaccine 3 days prior to entering the office. Due to research shows the Flu vaccine can shed. (you can possibly infect others) The COVID vaccine is new and we do not have research to determine the ability to do the same.
- I am responsible for keeping myself safe that includes wiping down surfaces in adjusting rooms, and any other area I may come in contact with.
- I acknowledge that I will be mindful of others and that I will remain 6 feet apart from other patients.
- I also acknowledge that some people are not able to wear a mask for health reasons and I agree to respect this.

I have acknowledge that I read the Covid-19 Health Waiver

Print Name:_____

Signature:_____ **Date:**_____