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: _____

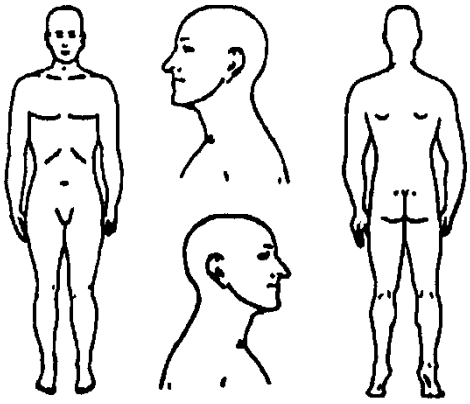
Date of last physical examination: _____ Do you smoke? □ No □Yes

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
Fever
Weight loss
Night sweats
Fatigue
Poor appetite

Sleep:
Gasping
Insomnia
Difficulty sleeping
Snoring
Restless legs

Ears:
Hearing loss
Ear pain
Ringing

Eyes:
Blurry vision
Double vision
Change in vision
Eye pain

Nose/Mouth &Throat:
Change of sense of smell
Nose bleeding
Sores in mouth
Difficulty or pain swallowing
Runny nose
Sores in mouth
Sore throat

Cardiovascular:
Chest pain
Swollen legs
Shortness of breath
Palpitations
Fainting

Respiratory:
Cough
Coughing up phlegm
Coughing up blood
Wheezing

Gastrointestinal:
Abdominal pain
Diarrhea
Constipation
Nausea
Vomiting
Heartburn

Musculoskeletal:
Muscle Pain
Joint Pain
Broken bones
Bone Pain
Swollen or red joints

Genitourinary:
Difficulty urinating
Kidney stone
Vaginal or penile discharge

Skin:
Rash
Moles that are changing
Ulcers that will not heal

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

Neurological:
Headaches
Seizure
Tremor
Stroke
Weakness
Dizziness
TIA's

Lymph and Heme:
Easy bleeding
Swollen lymph nodes

Psychiatric:
Depression
Hallucinations
Anxiety

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:_____

OFFICE POLICIES

To help you receive the best, all patients are accepted for care based on the following policies:

Our mission here at Evans Family Chiropractors is to serve as many families as humanly possible to achieve optimal health and healing through natural chiropractic care.

REFERRALS:
The greatest honor patients can give to their doctor is the referral of their family and friends. We promise to give your loved ones the same quality, love, and attention that you receive. Thank you in advance!

CHILDREN AND FAMILIES:
Once you understand that the nervous system controls all functions of the body, and subluxation interferes with the nerve flow, we expect that you would want everyone in your family checked. We offer a cost-effective program by extending the opportunity to have your family checked at our expense within two weeks of starting your care.

HALF HOUR TO HEALTH:
All new patients are required to attend this orientation with their spouse (if applicable). This dynamic session will help enhance your knowledge of Chiropractic care and aid tremendously in your healing process. We strongly encourage you to bring guests so they too can learn about health and healing. It's a life-changing event!

PREFERRED HOURS:
In order to provide the care you need as conveniently and rapidly as possible, we ask that your appointments are scheduled during the appropriate times:

Monday 7:30a-11:00a & 3:00pm-6:30pm
Tuesday 3:00pm-6:30pm
Wednesday 7:30a-11:00a & 3:00pm-6:30am
Thursday 7:30a-11:00a & 3:00pm-6:30pm

RESCHEDULING OR CHANGING APPOINTMENTS:
Dr. Denise has set up a specific course of care for you. A specific number of adjustments in a set amount of time are necessary to get the desired results. If you need to change the time of your appointment, it is imperative that you reschedule within the same day. We ask for at least a 12-hour notice if you need to reschedule or change your appointment. If you need to change your time for that day it is better to come in earlier than later, since we get busier in the later hours of the day. Please remember to tell the staff if you are going out of town, on business, or vacation. Multiple missed appointments are subject to charge.

- **Our massage policy requires a 24-hour notice for cancellation. If an appointment is missed without notice, the massage therapist will charge the full fee.**

FINANCIAL AGREEMENTS:
It is your payment that allows us to continue providing high levels of professional care, maintaining our facility, and pay our staff. If for any reason you cannot maintain your financial agreement, inform the doctor immediately. If you have the desire to receive care in our office, we will make every attempt to make an affordable arrangement.

PAYMENTS:
Full payment is due at the time of service unless prior arrangements have been made. We accept cash, personal checks, Visa, MasterCard, American Express, and Discover. We have a zero balance policy. If a check is returned for insufficient funds additional fees will apply.

TERMINATING YOUR CARE:
In the event you choose to discontinue your care for any reason, or we regretfully find it necessary to discharge you from our care, any outstanding fees become immediately due and payable at the appropriate fee for service. Any refunds or demand for payment are based on the standard fee for service to that point.

CHIROPRACTIC EXCELLENCE:
In order to continue providing the best in chiropractic care, Dr. Evans occasionally needs to be away from the office to attend conferences and continuing educational seminars. So that we may continue with your recommended adjustment schedule another highly qualified doctor may be here for you in the Doctor's absence.

DISCOURAGEMENT:
It is not the intent in our office to diagnose, treat, cure, or give any advice regarding any physical, mental, or emotional ailments other than the detection and correction of vertebral subluxations.

I have read and understand the above policies and agree to abide by them:

SIGNATURE: _____ DATE: _____

ADDITIONAL FAMILY MEMBERS' SIGNATURE: _____