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Date: \_\_\_\_\_ 12/2021

**GENERAL INFORMATION** (If more space is needed when filling in certain sections, please feel free to provide separate sheet)

First name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender:  Male  Female

Address, City, State, ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation / Job Title: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ City \_\_\_\_\_

Referring Provider: \_\_\_\_\_ City \_\_\_\_\_

How did you hear about Evergreen?  Friend  Website / Internet Search  Social Media

Other \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

If patient is under the age of 18:

Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Insurance / Payment Information**

*Most alternative medicine and wellness services are not covered by insurance. If you have questions or would like a superbill to submit to insurance please let us know. Knowledge and awareness of insurance coverage is the sole responsibility of the patient/client. Payment is due at the time of service, no exceptions.*

Insurance Co: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

Do you have a Health Savings Account (HSA) or Flexible Savings Account (FSA) ?  Yes  No

Worker's Comp Carrier \_\_\_\_\_

Name \_\_\_\_\_

**Structural Care Questionnaire**

What is the main reason for your Chiropractic evaluation today?

\_\_\_\_\_

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), circle the number that best describes your average pain?

0 1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

Days ago  Weeks ago  Months ago  Years ago

Other \_\_\_\_\_

Problem **worsens** with:

Movement  Inactivity  Standing  Lying  Sitting

Other \_\_\_\_\_

Problem **improves** with:

Movement  Inactivity  Standing  Lying

Sitting  Rest  Medication  Heat  Ice

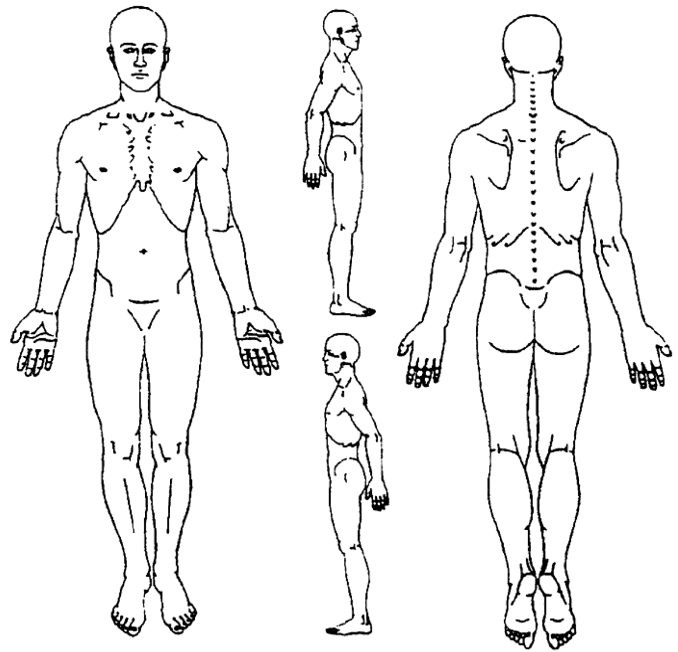
Other \_\_\_\_\_

How frequently are you bothered by this problem?

Constant  Occasional/Variable

Other \_\_\_\_\_

**Circle below where it hurts**



If pain is associated with your condition, please check all that apply:

Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning

Tingling  Cramps  Stiffness  Swelling  Other \_\_\_\_\_

Do you have any other symptoms?

Yes  No If yes, Please explain \_\_\_\_\_

Does the problem interfere with daily functions? No Yes, please explain \_\_\_\_\_

Is this condition getting:  Better  Worse  About the Same

Other comments you think are important \_\_\_\_\_

**ASQ – Appraisal and Symptom Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

The Health Appraisal and Symptom Questionnaire is designed to elucidate symptoms that help to identify the underlying causes of illness, as well as help track your progress over time, and give us more than a perfunctory picture of your general health. If you actually read this paragraph, please give Dr. Hales a hard time about the words “elucidate” and “perfunctory.”

Based on the past 90 days, please check any symptoms you have / have had below:

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Digestive Tract

- Frequent nausea or vomiting
- Diarrhea or constipation
- Bloating feeling after eating
- Food sensitivities
- Other \_\_\_\_\_

Emotions

- Anxiety, irritability
- Depression
- Mood swings
- Other \_\_\_\_\_

Energy / Activity

- Fatigue, sluggishness
- Hyperactivity or restlessness
- Restless legs
- Awake feeling unrefreshed / tired
- Frequent illnesses
- Other \_\_\_\_\_

Eyes / Ears

- Watery or itchy eyes
- Blurred or tunnel vision
- Frequent earaches or ear infections
- Ringing in ears, hearing loss
- Other \_\_\_\_\_

Head

- Headaches, including migraine headaches
- Faintness
- Dizziness or vertigo
- Other \_\_\_\_\_

Heart

- Rapid or pounding heartbeat
- Chest pain
- Other \_\_\_\_\_

Joints/Muscles

- Pain or aches in joints or arthritis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Muscle cramping
- Other \_\_\_\_\_

Lungs

- Frequent chest congestion
- Asthma, bronchitis
- Shortness of breath
- Other \_\_\_\_\_

Mind

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Stuttered / slurred speech
- Insomnia
- Other \_\_\_\_\_

Nose

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation
- Other \_\_\_\_\_

Skin / Hair / Nails

- Acne
- Hair loss or thinning
- Frequent rashes
- Excessive or lack of sweating
- Brittle nails
- Body odor offensive or strong
- Frequently cold hands or feet
- Other \_\_\_\_\_

Mouth / Throat

- Chronic coughing
- Frequent throat clearing
- Swollen/discolored tongue, gums, lips
- Gums infection / bleeding
- Other \_\_\_\_\_

Genitourinary

- Frequent or urgent urination
- Urinary tract infections
- Genital itch/discharge or STD outbreak
- Other \_\_\_\_\_

Hormones

- Low or high libido
- Impotence
- Facial or unusual hair growth
- Dizziness when standing
- Hot flashes
- Painful or abnormal periods
- Moderate to severe PMS
- Other \_\_\_\_\_

**Diagnosis / Conditions**

List any medical conditions or diagnoses, or any other health concerns beyond your primary complaint

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**Medical History**

Recent hospitalizations or surgeries (within the last 12 months)  None

Date \_\_\_\_\_ Reason \_\_\_\_\_

Date \_\_\_\_\_ Reason \_\_\_\_\_

**Allergies / Sensitivities**

Medication / supplement / food

Reaction

_____	_____
_____	_____
_____	_____
_____	_____

Current and Recent (last 90 days) Medications *(both prescription and over-the-counter)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Nutritional Supplements: *(Vitamins, Minerals, Herbs, & Homeopathy)* *If more space is needed, please write on a separate sheet.*

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems?  Yes  No

Describe: \_\_\_\_\_

## **INFORMED CONSENT**

Where and when indicated that I may benefit from the services of Evergreen Health Clinics I hereby request and consent to the performance of physical medicine procedures, chiropractic adjustments, muscle therapies and other usual and customary medical procedures. This may include examination tests, diagnostic x-rays, and other physical therapy techniques, on me (or on the patient named below for which I am legally responsible) recommended by providers and assistants of Evergreen Health Clinics who render treatment or recommendations to me.

I understand that, as with any health care procedures, there are certain complications that may arise during a functional health visit, chiropractic adjustment, or physical therapy session. The clinical procedures performed are usually beneficial to the patient and seldom cause any problem. In rare cases the following may occur, but are not limited to; fractures, disc injuries, bruising, tenderness from treatment, rare reactions from taping, sprain / strains, and discomfort from procedures. I have relayed all pertinent health information to the best of my knowledge and I do not expect the providers to be able to anticipate all risks and complications. I wish to rely on the staff's expertise and exercise judgment during the course of the procedures at the time and based upon the facts then known, and in my best interest.

I will assume all responsibility / liability if I withhold or do not report on the health forms any past medical history, illnesses, medications, or allergies.

I understand I will have an opportunity to ask questions and discuss with the providers of Evergreen Health Clinics and/or with office personnel about the nature, purpose and risks and other recommended procedures. I understand that in the process of receiving treatment, as with any health procedure, there is no guarantee of results.

I understand that herbal therapy involves recommendations and is not medical care, and does not make medical diagnoses. Herbalists at Evergreen are not trained as an MD, DO, or other medical provider. Herbalism in the United States is not a licensed profession.

I have read (or have had read to me) the above informed consent. By signing below, I state that I have weighed the risks involved in the potential treatment[s] and have decided that it is in my best interest to undergo treatment recommended and hereby give my consent to said treatment. I intend this consent form to cover the entire course of treatment for my (or the patient whom I am legally responsible for) present condition and for any future conditions for which I may seek treatment.

**Do not sign until you have read and understood the above information**

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Patient Printed Name

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Patient or Legal Guardian Signature / Date

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Witness / Employee Signature / Date

## CLINIC POLICIES

I authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to me (or on the patient named below for which I am legally responsible) to third party payers and/or other health practitioners and/or collection agency for account payment and/or to benefit the patient in achieving better health. I authorize and request my insurance company to pay directly to the provider or provider's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. **I agree to be responsible for payment of all services rendered to me or my dependents.**

**Missed or Cancelled Appointments:** We have both walk-in and scheduled appointments. If you have a scheduled appointment, please give us 24 hours notice if you need to make any changes to your scheduled appointment. If the nature of your visit is routine, we welcome you to come in at your convenience without an appointment. Missed or cancelled appointments without 24-hour advance notice may be subject to a "cancellation fee" of 50% of the standard appointment rate.

**Returned Checks:** There will be a \$25 administrative fee for all returned checks.

**Assignment of Benefits:** When using insurance, we will be providing treatments and await payment from your insurance company. This form instructs your insurance company to send their payments directly to this office. If your insurance company sends you payments for services provided by this office, you agree to pay Evergreen Health Clinics within 10 days the amount you received, plus any additional due for the specific services reimbursed by the payment received. A \$25 administration charge for any original checks cashed or not returned to this office within 10 days.

**Release of Information:** Your insurance reserves the right to deny payment if certain information relative to your care is not provided. If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

### Notice of Privacy Practices

As required by Privacy Regulations, Evergreen Health Clinics has made me aware of the "NOTICE OF PRIVACY PRACTICES".

I understand that Evergreen Physical Medicine follows H.I.P.A.A guidelines. **Initial your option below:**

\_\_\_\_\_ I wish to receive a paper copy of the Privacy Notice.

\_\_\_\_\_ I do not request a copy of the Privacy Notice, at this time. I acknowledge that I can request a copy at any time in the future.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient or Legal Guardian Signature / Date

\_\_\_\_\_  
Witness / Employee Signature / Date

# TERMS OF ACCEPTANCE

AS USED IN THESE DOCUMENTS, THE TERMS "WE," "OUR" AND/OR "US" REFERS TO EVERGREEN HEALTH CLINICS

## EXPLANATION OF SERVICES

**Structural Therapy** – If you have a new or existing physical problem and we discover that we can help we have a team ensuring your health goals are met. Our providers take a hands-on approach to problem solving many musculoskeletal problems. Our integrative approach of physical therapy, chiropractic, and functional health allow us to thoroughly, but quickly determine if we can help you, and if we can't we will make an appropriate referral.

To determine if you are a candidate for our non-surgical approach to healing you can expect a comprehensive exam and, if necessary, additional testing, including lab work and/or x-rays.

**Functional Health** – If you are feeling unwell and don't know why or are suffering from a chronic or autoimmune condition, we may be able to help. Functional Health at Evergreen blends the functional and structural, integrating principles of functional medicine, chiropractic, and herbalism for chronic illness, inflammation, toxicity, digestive problems, emotional difficulties, and/or physical obstacles that are preventing your improved health.

**Foundations of Health** – Daily activities can cause joint dysfunction or fixations of the spine. These joint dysfunctions or fixations, also known as subluxations, can interfere with the proper neuro-electrical communication of your nervous system. As a result, you can experience aches, pain, decreased joint movement, and/or a decrease in proper body function.

Our Foundations of Health program focuses on removing joint restrictions to restore the proper communication of the nervous system through ongoing chiropractic treatment for maintenance and preventative care.

## WHAT SERVICE IS BEST FOR YOU?

We want you to get the health service that you need and the health and safety of the people we serve is of the utmost importance to us. Our initial intake review and assessment is designed to get you to the most appropriate provider(s) for your needs

I, \_\_\_\_\_ have read and fully understand the above statements. All questions concerning the office

(Patient Printed Name)

objectives pertaining to the care I need have been answered to my satisfaction. I therefore accept structural therapy, functional health, and/or Foundations of Health care provided to me at this location and will make any objections known to the staff.

\_\_\_\_\_  
Patient Signature / Date

## CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, \_\_\_\_\_ of \_\_\_\_\_ have read and fully understand

(Parent or Legal Guardian)

(Child's or Ward's Name)

the terms of acceptance and hereby grant permission for my child / ward to receive care at Evergreen Health Clinics.

\_\_\_\_\_  
Parent or Legal Guardian Signature / Date