evergreen
HEALTH CLINICS

1710 W Cherry Dr., Meridian, ID 83642
208.895.8595 • Fax: 208.895.8594

Date: _____

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: _____ Gender: ☐ Male ☐ Female

Primary Address: _____
City, State Zip: _____
Alternate Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Emergency Contact: _____ Phone: _____
Relationship to you: _____ Address: _____
City, State Zip: _____

Job Title: _____
Nature of Business: _____

Primary Care Provider: _____ May we contact? ☐ Yes ☐ No

Whom may we thank for referring you? _____
☐ Friend ☐ Website / Internet Search ☐ Social Media ☐ Other
_____

Insurance / Payment Information
Functional medicine and wellness services are generally 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

Health Concerns & Goals
What are your symptoms? _____
_____
When did they start? _____
What makes them better?
_____

What makes them worse? _____

What are your patterns and/or triggers? _____

When was the last time you felt exceptionally well? _____

What led to or preceded feeling well? _____

Is this condition getting: ☐ Better ☐ Worse ☐ About the same

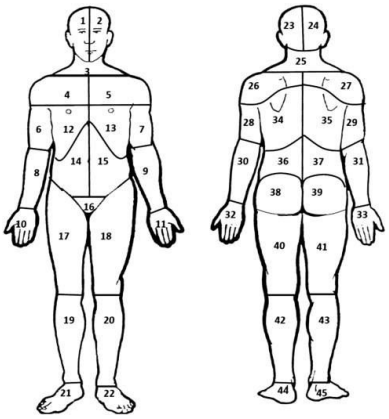
Is this condition constant, or does it come and go? _____

Other comments you think are important: _____

_____

_____

Circle any areas that you are experiencing pain/discomfort:



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

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning

☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

In the past 12 months, have you experienced any of the following:

☐ abnormal bleeding ☐ stools that look like black coffee ☐ significant change in appetite
☐ constipation which does not respond to treatment ☐ sudden, unintentional or unexplained weight loss
☐ weight gain when dieting ☐ sudden change in bowel habits ☐ unexplained vomiting
☐ lumps and bumps ☐ difficulty swallowing ☐ progressively worsening headache, or any other kind of pain
☐ unexplained exhaustion or tiredness ☐ changes in sleeping patterns ☐ disturbed vision
☐ persistent cough over three weeks, or breathing difficulties ☐ lack of urine
☐ waking up with breathing difficulties, especially if sitting up brings improvement

Medical History

Please list all other healthcare providers with whom you have received treatment within the last 12 months: (DC / MD/ DO / PT / ND / Acupuncture, etc.)

Name: _____ *City:*_____
Treatment Focus: _____
Name: _____ *City:*_____
Treatment Focus: _____
Name: _____ *City:*_____
Treatment Focus: _____

Hospitalizations ☐ None

*Date*_____ - *Reason* _____

_____ - _____

Allergies

Medication / supplement / food *Reaction*

_____ _____

_____ _____

_____ _____

_____ _____

Medications

Current Medications *(both prescription and over-the-counter)*

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

Previous Medications*: Last 10 Years*

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

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

For what reason, and for how long, did/do you use pain relievers? _____

Antibiotic History

Have you taken antibiotics **more than** 1 x per year? ☐ Yes ☐ No Why?

_____

Have you had long-term use of antibiotics? *(more than 10 days)* ☐ Yes ☐ No Why?

_____

How many times have you taken antibiotics throughout your lifetime? _____
Which antibiotic types have you taken? _____

Other

Significant silver dental fillings? ☐ Yes ☐ No How many? _____
Significant mold exposure? ☐ Yes ☐ No When & how long? _____
Any tick bites? ☐ Yes ☐ No Details _____

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. Rate each of the following symptoms based upon your health profile for the past 90 days.

POINT SCALE:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is significant
3 = Frequently have it, effect is significant
4 = Frequently have it, effect is very significant

Digestive Tract
___ Nausea or vomiting
___ Diarrhea (loose stools or >3x/day)
___ Constipation (not going everyday)
___ Bloated feeling or abdominal swelling
___ Belching or passing gas
___ Heartburn or GERD
___ Intestinal or stomach pain
___ Reactions to foods
___ Gallstones or pain after fatty meals
___ Bad breath
___ Blood or mucous in stool
___ Other_____
Total _____

Ears
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
___ Other_____
Total _____

Emotions
___ Mood swings or outbursts
___ Anxiety, irritability
___ Depression
___ Other_____
Total _____

Energy / Activity
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity or restlessness
___ Restless legs
___ Awake feeling un-refreshed / tired
___ General feeling of ill health
___ Frequent illness
___ Other_____
Total _____

Eyes
___ Watery or itchy eyes
___ Swollen, reddened, or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision *(does not include near-or-far-sightedness)*
___ Other_____
Total _____

Head
___ Headaches
___ Faintness
___ Dizziness or vertigo
___ Other_____
Total _____

Heart
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
___ Other_____
Total _____

Joints/Muscles
___ Pain or aches in joints or arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
___ Muscle cramping
___ Other_____
Total _____

Lungs
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing
___ Inability to take deep breaths
___ Other_____
Total _____

Mind
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Stuttered / slurred speech
___ Insomnia
___ Learning disabilities
___ Other_____
Total _____

Nose
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation
___ Other_____
Total _____

Skin
___ Acne
___ Hives
___ Hair loss or thinning
___ Rash or reddened skin
___ Excessive or lack of sweating
___ Edema
___ Dry or oily skin
___ Dry, cracked nails
___ Body odor offensive or strong
___ Odd or changing moles
___ Other_____
Total _____

Weight
___ Binge / compulsive eating
___ Craving certain foods
___ Excessive weight
___ Water retention
___ Underweight
___ Other_____
Total _____

Mouth / Throat
___ Chronic coughing
___ Gagging, frequent throat clearing
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gums, lips
___ Gums infection / bleeding
___ Canker sores
___ Sticky coating on tongue
___ Dry, cracked lips
___ Other_____
Total _____

Genitourinary
___ Frequent or urgent urination
___ Urinary tract infections
___ Incontinence

___ Genital itch/discharge or STD outbreak
___ Vaginal discharge / yeast / odor
___ Odd color urine (red, brown, black)
___ Other_____
Total _____

Hormones
___ Low or high libido
___ Impotence
___ Facial or unusual hair growth
___ Cold hands or feet
___ Frequent thirst
___ Dizziness when standing
___ Flushing or hot flashes
___ Painful or abnormal periods
___ Other _____
*Total*_____

Grand Total _____

Diseases/Diagnosis/Conditions: *Check appropriate box and provide Month/Year of onset* ☐ *Past Condition* ☐ *Ongoing Condition*

Gastrointestinal
☐ ☐ Irritable Bowel Syndrome ___ /____
☐ ☐ Inflammatory Bowel Disease ___ /____
☐ ☐ Crohn's ___ /____
☐ ☐ Ulcerative Colitis ___ /____
☐ ☐ Gastritis or Peptic Ulcer Disease ___ /____
☐ ☐ Celiac Disease ___ /____
☐ ☐ Hemorrhoids ___ /____
☐ ☐ Other ___ /____ _____

Cardiovascular
☐ ☐ Heart Attack ___ /____
☐ ☐ Other Heart Disease ___ /____
☐ ☐ Stroke ___ /____
☐ ☐ Elevated Cholesterol ___ /____
☐ ☐ Arrhythmia *(irregular heart rate)* ___ /____
☐ ☐ High or low blood pressure ___ /____
☐ ☐ Rheumatic Fever ___ /____
☐ ☐ Mitral Valve Fever ___ /____
☐ ☐ Other ___ /____ _____

Cancer
☐ ☐ Type(s) ___ /____

Genitourinary Systems
☐ ☐ Kidney Stones ___ /____
☐ ☐ Gout ___ /____
☐ ☐ Interstitial Cystitis ___ /____
☐ ☐ Other ___ /____ _____

Metabolic/Endocrine
☐ ☐ Type 1 Diabetes ___ /____
☐ ☐ Type 2 Diabetes ___ /____
☐ ☐ Hypoglycemia ___ /____
☐ ☐ Metabolic Syndrome *(Insulin Resistance/ Pre-Diabetes)*___ /____
☐ ☐ Hypothyroidism *(low thyroid)* ___ /____
☐ ☐ Hyperthyroidism *(overactive thyroid)* ___ /____
☐ ☐ Endocrine Problems ___ /____
☐ ☐ Polycystic Ovarian Syndrome *(PCOS)* ___ /____
☐ ☐ Infertility ___ /____
☐ ☐ Night Eating Syndrome ___ /____
☐ ☐ Eating Disorder ___ /____ _____
☐ ☐ Other ___ /____ _____

Musculoskeletal/Pain
☐ ☐ Fibromyalgia ___ /____
☐ ☐ Chronic Pain ___ /____
☐ ☐ Tendonitis ___ /____
☐ ☐ TMJ Problems ___ /____
☐ ☐ Joint Deformity ___ /____
☐ ☐ Other ___ /____ _____

Inflammatory / Autoimmune
☐ ☐ Chronic Fatigue Syndrome ___ /____
☐ ☐ Autoimmune Disease ___ /____
☐ ☐ Rheumatoid Arthritis ___ /____
☐ ☐ Lupus SLE ___ /____
☐ ☐ Immune Deficiency Disease ___ /____
☐ ☐ Herpes-Genital ___ /____
☐ ☐ Cold Sores ___ /____
☐ ☐ Shingles ___ /____
☐ ☐ Severe Infectious Disease ___ /____
☐ ☐ Other ___ /____ _____

Respiratory Diseases
☐ ☐ Emphysema ___ /____
☐ ☐ Tuberculosis ___ /____
☐ ☐ Sleep Apnea ___ /____
☐ ☐ Other ___ /____ _____

Head, Eyes, & Ears
☐ ☐ Macular Degeneration ___ /____
☐ ☐ Vitreous Detachment ___ /____
☐ ☐ Retinal Detachment ___ /____
☐ ☐ Other ___ /____ _____

Skin Diseases
☐ ☐ Vitiligo ___ /____
☐ ☐ Eczema ___ /____
☐ ☐ Psoriasis ___ /____
☐ ☐ Other ___ /____ _____

Neurologic / Mood
☐ ☐ Depression ___ /____
☐ ☐ Anxiety ___ /____
☐ ☐ Bipolar Disorder ___ /____
☐ ☐ Schizophrenia ___ /____
☐ ☐ ADD/ADHD ___ /____
☐ ☐ Autism ___ /____
☐ ☐ Mild Cognitive Impairment ___ /____
☐ ☐ Parkinson's Disease ___ /____
☐ ☐ Multiple Sclerosis ___ /____
☐ ☐ ALS ___ /____
☐ ☐ Seizures ___ /____
☐ ☐ Other ___ /____ _____

Female Reproductive
☐ ☐ Breast Cysts ___ /____
☐ ☐ Breast Lumps ___ /____
☐ ☐ Ovarian Cysts ___ /____
☐ ☐ Other ___ /____ _____

Male Reproductive
☐ ☐ Prostatitis *(Inflammation)* ___ /____
☐ ☐ Other ___ /____ _____

Surgeries
Check box if yes and provide date of surgery
☐ None
☐ Appendectomy ___ /____
☐ Hysterectomy +/- Ovaries ___ /____
☐ Gall Bladder ___ /____
☐ Hernia ___ /____
☐ Tonsillectomy ___ /____
☐ Dental Surgery ___ /____
☐ Joint Replacement: Knee/Hip ___ /____
☐ Heart Surgery: Bypass Valve ___ /____
☐ Angioplasty or Stent ___ /____
☐ Pacemaker ___ /____
☐ Other ___ /____ _____

Preventive Tests

Check box if yes and provide date of most recent test

☐ Blood Tests ___ /____
☐ Full Physical Exam ___ /____
☐ X-Ray ___ /____ *Body Part?*_____
☐ Bone Density ___ /____
☐ Colonoscopy ___ /____
☐ Cardiac Stress Test ___ /____
☐ EKG ___ /____
☐ Hemoccult Test (stool test for blood) ___ /____
☐ MRI ___ /____
☐ CT Scan ___ /____
☐ Upper Endoscopy ___ /____
☐ Upper GI Series ___ /____
☐ Ultrasound ___ /____
☐ Other ___ /____ _____

Blood Type
☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ unknown

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 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

_____
Patient Printed Name

_____
Patient or Legal Guardian Signature / Date

_____
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