# Welcome to Evolution Chiropractic

Please fill out this form as completely and accurately as possible.
All the information requested below, is necessary for us to serve you the best way possible

Today's Date__________________

## PERSONAL DATA

Name_____________________________________ Age_____________ Date of Birth______________________

Parent's names (if you are under 18)_______________________________________________________________

Home Address________________________________________City_____________ State__________ Zip________

Home phone (____) ______________ Cell phone(_____) ______________ Email address ______________________

Occupation____________________ Employer ________________________________________________________

Business Address_________________________ City _________________ State __________________ Zip________

Business Phone (_____) ____________________ SS# __________________________________________________

Marital Status S M D W L/D Name of Spouse ________________________________________________

Names of Children ____________________________________________________________________________

Whom may we thank for referring you to our office? __________________________________________________

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Evolution Chiropractic can address for you? ____________________________________
_______________________________________________________________________________________________

Is this concern affecting your quality of life? (Please circle only those applicable to you)

| | | | | | |
|---|---|---|---|---|---|
| Work: | Y N | Recreation: | Y N | Sleep: | Y N |
| School: | Y N | Walking: | Y N | Sitting: | Y N |
| Exercise/sports | Y N | Eating: | Y N | Love Life: | Y N |

## HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic Care? Y N With whom________________________

How long under care? ___________ Date of last visit:________ Why did you stop?______________

Was there a particular health concern for which you consulted the chiropractor?

_______________________________________________________________________________

Have you consulted or do you regularly consult any of the following care providers? (Check all that apply)

| | | | |
|---|---|---|---|
| ❑ Medical Physician | ❑ Naturopathy | ❑ Acupuncturist | ❑ Homeopath |
| ❑ Massage Therapist | ❑ Psychotherapist | ❑ Energy Healer | ❑ Dentist |

Reasons why: ________________________________________________________________________

*FOR WOMAN*

Are you pregnant? Y N Date of last Menstrual Period:_____________________________________________

If pregnant, what is due date?_____________ Name of OBGYN or Midwife _________________________________

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other __________________

## HEALTH, WELLNESS AND CHIROPRACTIC CARE

The human body is designed to be healthy. The primary system in the body which coordinates health is the NERVE SYSTEM. The vertebrae, (bones of the spine) surround and protect the delicate NERVE SYSTEM.

Physical, emotional and chemical stresses, common to our contemporary lifestyles, can result in misalignment to the spinal coumn as well as damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic Exam/evaluation determines if your spine shows signs of the Vertebral Subluxation process.

Please review and indicate your history of "stresses" (below) so that we can assess their relationship to your present health status and examination findings. We will discuss this during the consultation.

## HISTORY OF PHYSICAL STRESSES (Birth to Present)

**The birth process can traumatize a baby's spine and cause damage to the nerve system. Please indicate to the best of your recollection where and how you were birthed. (check all that apply)**

**If you do not know, please skip to next question**

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑Forcepts

❑Breech ❑ Cord around neck ❑Prolonged labor ❑ Drug induced labor ❑ Suction

**The information below will help us to see the types of PHYSICAL stresses that you have been subjected to and how they may relate to your present health status.**

Have you had any accidents related to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑Playground ❑ Abuse

If yes, please explain how and dates: ______________________________________________________________________________

______________________________________________________________________________________________

Have you ever injured your spine (Head, neck, rib/chest area, back, pelvis or hips)? Y N

If yes, please explain how and dates: ______________________________________________________________________________

______________________________________________________________________________________________

Have you ever broken any bones or sprained any part of your body? Y N

If yes, please explain how and dates: ______________________________________________________________________________

______________________________________________________________________________________________

Have you ever been hospitalized? Y N

If yes, please explain how and dates: ______________________________________________________________________________

______________________________________________________________________________________________

## HISTORY OF CHEMICAL STRESSES

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic ot the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.)

The following will give us insight into any exposures you may have had.

Were you vaccinated? Y N If yes, did you have a reaction? Y N

Have you been exposed to any of the following on a regular basis, (past or present)?

❑ Toxic Chemicals ❑ Drugs (prescribed or not) ❑ Second hand smoke ❑Other

If yes, please explain: ______________________________________________________________________________

So you have allergies to any foods? Y N If yes, please describe: ________________________________________________

______________________________________________________________________________________________

Would you like to know how food allergies and food sensitivities can effect your overall health and how to identify them? Y N

Do you consume any of the following presently?

❑Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ OTC drugs ❑ Prescribed Drugs

Please list all medications (prescribed and OTC): _____________________________________________________________

______________________________________________________________________________________________

*Note: it is imperative that you list all medications as they may have an influence on your care.*

## HISTORY OF EMOTIONAL STRESSES

It is difficult to separate the emotional stress in our life from the physical response that often occurs.

Please indicate if you have experienced any of the emotional stresses below:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Childhood Trauma: | Y | N | Loss of loved one: | Y | N | Abuse: | Y | N |
| Work or School: | Y | N | Divorce/separation: | Y | N | Financial: | Y | N |
| Lifestyle Change: | Y | N | Parents divorce: | Y | N | Illness: | Y | N |

## QUALITY OF LIFE

| | | | |
|---|---|---|---|
| How do you grade your physical health? | ❑ Good | ❑ Fair | ❑ Poor |
| How do you grade your emotional/mental health? | ❑ Good | ❑ Fair | ❑ Poor |
| How do you rate your overall “quality of life”? | ❑ Good | ❑ Fair | ❑ Poor |

## EXPECTATIONS

As a result of my Chiropractic Care, I would like to: (Check all that apply)

❑ Feel better quickly ❑ Have a healthier nerve system

❑ Have a healthier spine ❑ have optimum health on all levels\

## FINANCIAL INFORMATION

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ Cash ❑ Check ❑ Credit Card ❑ Insurance

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. If you determine that your insurance covers Chiropractic Care and you would like us to assist you in the billing process, you must FIRST fill out an "Insurance Verification Form"'(IVF), to indicate the amount and extent of coverage. Once the IVF is complete, we will gladly submit bills on your behalf.

If you have insurance that will reimburse for Chiropractic services, please indicate the type of policy and name of Insurance carrier:

❑ Health Insurance ❑ Auto Accident ❑ Medicare ❑ Workers Compensation

Name of Insurance Company:_____________________________________________________________________

If this is an Auto Accident, please provide us with the following information:

Have you been treated elsewhere? ❑ Emergency Room ❑ Primary Care Doctor ❑ Other

What services were provided? ❑ MRI ❑ X-Rays ❑ Medication ❑ Therapy ❑ Other

*The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Shawn Carlin permission to render care to me today. This initial visit includes a health history/consultation, Chiropractic exam/ evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.*

*Signature*______________________________________________________*Today's Date*__________________

*Signature of Parent (for minor)*_____________________________________*Today's Date*__________________