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CONFIDENTIAL PATIENT HEALTH HISTORY INFORMATION

Name: _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Pager # _____

Cellular Phone# _____ Today's Date _____ Your Sex: □ Male □ Female

E-mail Address: _____ Would you like us to e-mail you our Health Newsletter? □ Yes □ No

Date of Birth _____ Marital Status(circle one): M S D W # of Children: _____ Ages of Children _____

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Work Phone # _____ SS# _____

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____ Zip _____

Spouse's Date of Birth _____

CURRENT HEALTH CONDITIONS

Purpose of this appointment: _____

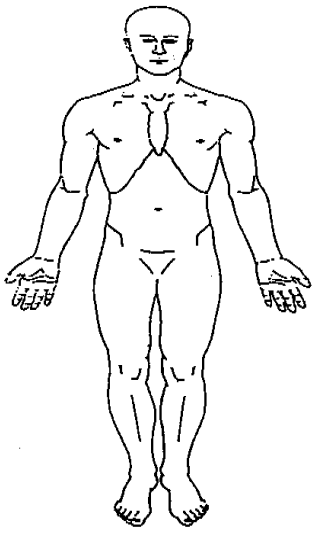
State your major complaint: _____

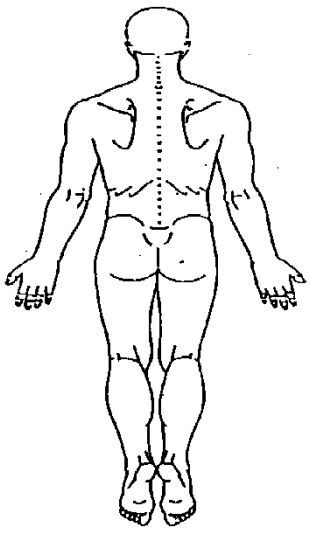
Is this condition: □ Job related □ Auto accident □ Home injury □ Other: _____ Date of accident: _____

How long have you had this complaint? _____ What started your symptoms? _____

What aggravates your symptoms?_____

Is there anything that makes your symptoms less intense? _____





Please mark the area of your complaint on the diagrams below

Do you in the present and/or have in the past experienced any of the following conditions?

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Hip pain	☐	☐	Fibromyalgia
☐	☐	Neck pain	☐	☐	Leg pain	☐	☐	Asthma
☐	☐	Mid back pain	☐	☐	Knee pain	☐	☐	Sinus condition
☐	☐	Low back pain	☐	☐	Ankle pain	☐	☐	High levels of stress
☐	☐	Disc injury	☐	☐	Difficulty walking	☐	☐	General fatigue
☐	☐	Sciatica	☐	☐	Numbness	☐	☐	Muscle weakness
☐	☐	Shoulder pain	☐	☐	A sensation of pins and needles	☐	☐	Anxiety
☐	☐	Arm pain	☐	☐	Numbness in fingers and/or toes	☐	☐	Difficulty sleeping
☐	☐	Elbow pain	☐	☐	Muscle stiffness	☐	☐	Scoliosis
☐	☐	Hand pain	☐	☐	Painful joints	☐	☐	Cancer

Have you ever had or experienced any of the following symptoms or conditions?

☐ Chest pain/tightness	☐ Neurological disorders	☐ Difficulty chewing/clicking jaw
☐ Pain over the heart	☐ Seizures	☐ Gastrointestinal disorders
☐ Heart palpitations	☐ Fever/chills	☐ Nausea/vomiting
☐ High blood pressure	☐ Psychiatric disorders	☐ Loss of appetite
☐ Family history of heart disease	☐ Epilepsy	☐ Liver/gall bladder disorders
☐ Cardiovascular/heart disorders	☐ Vision/eye disorders	☐ Excessive thirst/hunger
☐ Dizziness/ fainting spells	☐ Chronic sore throat	☐ Hypoglycemia
☐ Stroke	☐ Dental/gum disorders	☐ Sudden weight loss/gain
☐ Pulmonary/lung disorders	☐ Chronic ear infections/hearing loss	☐ High blood sugar (Diabetes)
☐ Shortness of breath/ breathing disorders	☐ Thyroid disorders	☐ High cholesterol
☐ Emphysema/pleurisy	☐ Skin disorders/recent skin changes	☐ Gynecological disorders
☐ Arthritis	☐ HIV positive/AIDS	☐ Breast disorders
☐ TMJ	☐ Varicose veins	☐ Menstrual disorders
☐ Gout	☐ Blood disorders	☐ Urinary/bladder disorders

GENERAL HEALTH INFORMATION

Are you currently taking any medication?	☐ YES	☐ NO	If yes, list: _____
Do you have any allergies (food, medication)?	☐ YES	☐ NO	If yes, list: _____
Is there any possibility that you might be pregnant?	☐ YES	☐ NO	
Are you taking birth control pills?	☐ YES	☐ NO	
Have you ever had an abnormal EKG/heart condition?	☐ YES	☐ NO	If yes, explain: _____
Have you had any surgeries or hospitalizations?	☐ YES	☐ NO	If yes, explain: _____
Do you have a history of fainting?	☐ YES	☐ NO	If yes, explain: _____
Do you smoke?	☐ YES	☐ NO	If yes, How Much? _____
Do you drink alcoholic beverages?	☐ YES	☐ NO	If yes, How Much? _____
Do you consume caffeinated beverages?	☐ YES	☐ NO	If yes, how many per day? _____
Is there any condition, which runs in your family?	☐ YES	☐ NO	If yes, What? _____

When was your last physical examination? _____

Have you seen any other physician for your condition? ☐Yes ☐No If yes, who:

INSURANCE INFORMATION

Primary Insurance Carrier _____ Secondary Insurance _____

AGREEMENT

I understand and agree that my insurance policies are an arrangement between my insurance carriers and myself, however I understand that I am ultimately responsible for my bill. I also understand that this office will prepare any necessary reports and/or forms to assist me in making collections from my insurance company. I authorize my insurance company to reimburse Michael S. Evangel, D.C. directly. Dr. Evangel. will credit my account upon receipt. I also understand that in the event I receive payments directly for services rendered and billed by Dr. Evangel., I will forward payments promptly to Dr. Evangel. I clearly understand and agree that there are no guaranteed results for care and/or treatment. I further understand that 1% interest per month may be added on my past balance to my account if it is delinquent for 60 days. I authorize Dr. Evangel to request or send any or all of my medical records, x-rays and/or billing records and/or information from or to any health care professional and/or insurance carrier that may require information/records that may be germane to my case.

Print Name: _____

Signature: _____ Date: _____

Parent/guardian's signature if under 18 years of age