

MICHAEL S. EVANGEL, D.C.

56 North Central Ave., Ramsey, NJ 07446

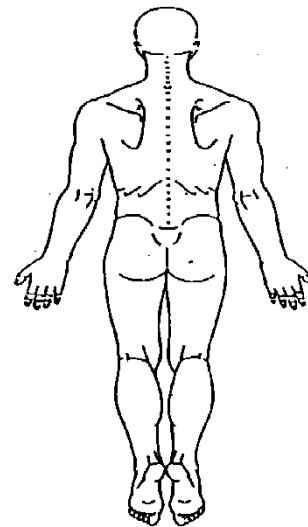
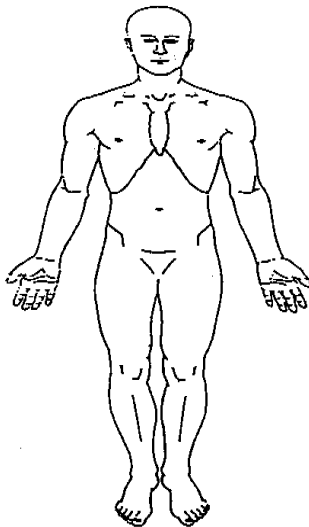
(201) 447-3800 Fax: (201) 447-3801

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

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

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