TERMS OF ACCEPTANCE

AS USED IN THESE DOCUMENTS, THE TERMS "WE," "OUR" AND/OR "US" REFERS TO EVERGREEN PHYSICAL MEDICINE.

EXPLANATION OF SERVICES

Physical Medicine – 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 primary medical providers take a hands-on approach to problem solving many musculoskeletal problems. Our integrative approach of primary and alternative care allows 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 Medicine – If you are feeling unwell and don't know why or are suffering from a chronic or autoimmune condition[s], we may be able to help. Functional Medicine strives to discover the cause by determining if inflammation, toxicity, digestive problems, emotional difficulties, and/or physical obstacles are preventing you from improved health. When we address the underlying cause, a patient will have increased energy and a decrease in pain and inflammation.

A thorough history, lab work, and examination procedures are used to create an individualized plan to improve function of the bodies systems using diet, supplements, detoxifying, and, structural protocols.

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 up most importance to us. That is why we only accept patients that we have utilized all our resources to determine will potentially benefit from our care.

To receive the most from the services we provide, it is important for us to understand what you feel most matches what is best for you:

Check all that apply

☐ **Physical Medicine**
Full Integrated Health Evaluation

☐ **Functional Medicine**
Find & Treat Cause of Condition

☐ **Foundations of Health**
Preventative & Maintenance Care

I, _____ have read and fully understand the above statements. All questions concerning the office objectives
(Patient Printed Name)
pertaining to the care I need have been answered to my satisfaction. I therefore accept all physical medicine, functional medicine, and/or chiropractic care provided to me at this location.

_____ _____
(Patient Signature) (Date)

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____ of _____ have read and fully understand the terms of acceptance and
(Parent or Legal Guardian) (Child/(ren) Name)
hereby grant permission for my child(ren) to receive care at Evergreen Physical Medicine.

_____ _____
(Parent or Legal Guardian Signature) (Date)

PATIENT INFORMATION

Name: _____ Date of Birth: ____ / ____ / _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ☐ W ☐ H ☐ C 2nd Phone: _____ ☐ W ☐ H ☐ C

Email: _____ SS: _____ / _____ / _____

Employer: _____ Occupation: _____

Marital Status: M S D W Other Spouses Name: _____ # of Children: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Co: _____ Insurance ID #: _____

Primary Doctor: _____ May We Contact? ☐ Yes ☐ No

What is your preferred method of communication? ☐ Phone ☐ Text ☐ Email

Are you Medicare Eligible? ☐ Yes ☐ No

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

How did you hear about Evergreen Physical Medicine? _____

If you were referred by someone please tell us who so we may thank them. _____

_____ _____

(Patient or Legal Guardian Signature) (Date)

PATIENT HISTORY

Name: _____ Date of Birth: ____ / ____ / _____ Age: _____ Gender ☐ M ☐ F

What is the primary problem that brought you here today? _____

Rate Pain / Discomfort (1 minimal 10 severe): 1 2 3 4 5 6 7 8 9 10 Discomfort affects me _____% of my day

Describe Discomfort: Dull Sharp Throbbing Burn Deep Aching
Tingling Stabbing Cramping Numbness Radiating Stiffness

Onset of Complaint Date: ____ / ____ / _____ How long have you had this symptom? _____

What makes symptoms worse? _____ What makes symptoms better? _____

Important history about this complaint: _____

Have you experienced this/these complaint(s) before? ☐ Yes ☐ No if yes, when? _____

Is there a secondary problem that brought you here today? _____

Rate Pain / Discomfort (1 minimal 10 severe): 1 2 3 4 5 6 7 8 9 10 Discomfort affects me _____% of my day

Describe Discomfort: Dull Sharp Throbbing Burn Deep Aching
Tingling Stabbing Cramping Numbness Radiating Stiffness

Onset of Complaint Date: ____ / ____ / _____ How long have you had this symptom? _____

What makes symptoms worse? _____ What makes symptoms better? _____

Important history about this complaint: _____

Have you experienced this/these complaint(s) before? ☐ Yes ☐ No if yes, when? _____

Have you had chiropractic care before? ☐ Yes ☐ No If yes, how recently? _____

Are you pregnant? ☐ Yes ☐ No ☐ N/A If yes, how many weeks? _____

Are you currently experiencing any of the following:

☐ Nausea or vomiting ☐ Dizziness ☐ Rapid eye movement ☐ Double vision
☐ Difficulty walking ☐ Difficulty speaking ☐ Difficulty swallowing ☐ Headache or neck pain
☐ Numbness on one side of the face or body ☐ Fainting or lightheadedness

(If yes to any, please describe) _____

Current prescriptions or over-the-counter medications: _____

PAST HISTORY: **MUSCULOSKELETAL CONDITIONS** (please check all that apply)

☐ Headaches/Migraines ☐ Hip Pain/Discomfort ☐ Arthritis
☐ Neck Pain/Discomfort ☐ Sciatica ☐ Fused/Fixated Joints
☐ Shoulder Pain/Discomfort ☐ Elbow Pain/Discomfort ☐ Herniated Disc
☐ Upper Back Pain/Discomfort ☐ Wrist Pain/Discomfort ☐ Joint Replacement
☐ Middle Back Pain/Discomfort ☐ Knee Pain/Discomfort ☐ Osteoporosis
☐ Low Back Pain/Discomfort ☐ Ankle Pain/Discomfort ☐ Osteopenia
☐ Inflammation/Swelling; where _____

OTHER CONDITIONS

☐ Cancer ☐ Heart Disease
☐ Tumors ☐ AIDS/HIV
☐ Stroke ☐ Diabetes
☐ Seizure Disorders ☐ Hepatitis
☐ High Blood Pressure ☐ Tuberculosis
☐ Pacemaker ☐ Hernia
☐ Allergies _____
☐ Other _____

Indicate if you have experienced any of the following and mark how recently.

Surgeries?	☐ Yes	☐ No	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months	____ yrs.
Accidents/Broken Bones?	☐ Yes	☐ No	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months	____ yrs.
Hospitalizations?	☐ Yes	☐ No	☐ Less than 1 month	☐ 1-6 months	☐ 6-12 months	☐ More than 12 months	____ yrs.

If yes to any, list and describe _____

Family History: (check all that apply) ☐Cancer ☐Tumors ☐Stroke ☐Seizures ☐Diabetes ☐High Blood Pressure ☐Heart Disease

_____ _____
(Patient or Legal Guardian Signature) (Date

INFORMED CONSENT

Where and when indicated that I may benefit from the services of Evergreen Physical Medicine 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 the doctor[s] of chiropractic, nurse practitioner, named and/or other therapists or technicians of Evergreen Physical Medicine 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 physical medicine visit, chiropractic adjustment or muscle 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, redness at injection site, 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 doctor or nurse practitioner 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 doctors and nurse practitioner of Evergreen Physical Medicine 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 on my behalf or my dependents behalf.***

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 advanced 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 shall bring in person or send certified mail the endorsed original insurance check immediately. 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 you're 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 Physical Medicine 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)

DETAILED HEALTH HISTORY

Name: _____ **Please check any health challenges you currently have or have experienced in the past**

Neurological
- ❑ Slurred Speech
- ❑ Ringing in ears
- ❑ Altered taste or smell
- ❑ Night blindness
- ❑ Stroke
- ❑ Parkinson's
- ❑ Forgetfulness
- ❑ Chronic pain
- ❑ Fibromyalgia
- ❑ Autoimmune Disease
- ❑ Blurred vision
- ❑ Multiple sclerosis
- ❑ Pace maker

Cardiovascular
- ❑ Chest pain
- ❑ Palpitations/racing heart
- ❑ Swelling in hands or feet
- ❑ Anemia / low iron
- ❑ Respiratory infections
- ❑ High cholesterol
- ❑ Swelling of ankles
- ❑ Heart Attack
- ❑ Wheezing / Asthma
- ❑ Heart Disease
- ❑ Difficulty breathing
- ❑ High blood pressure
- ❑ COPD
- ❑ Emphysema

Gastrointestinal
- ❑ Frequently Sick
- ❑ Stomach pains
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Crohn's / Colitis
- ❑ Hemorrhoids
- ❑ Gas or bloating
- ❑ Nausea / vomiting
- ❑ Hypoglycemia
- ❑ Diabetes (1 or 2)
- ❑ Excessive thirst
- ❑ Liver problems
- ❑ Pain over stomach

Ears /Nose /Throat
- ❑ Sore throat
- ❑ Gingivitis
- ❑ Recurrent sinus pain
- ❑ Nose bleeds
- ❑ Allergies
- ❑ Dry eyes
- ❑ Corrective lens
- ❑ Chronic cough
- ❑ Pneumonia
- ❑ Sinus infections
- ❑ Hoarseness
- ❑ Eye pain
- ❑ Ringing in ears
- ❑ Ear Infections

Skin
- ❑ Eczema
- ❑ Dermatitis
- ❑ Rashes
- ❑ Hair loss
- ❑ Bleeding disorders
- ❑ Varicose veins
- ❑ Excessive acne
- ❑ _____
- ❑ _____

Weight
- ❑ Decreased appetite
- ❑ Weight gain
- ❑ Trouble losing weight
- ❑ Binge eating
- ❑ Water retention
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Excessive hunger
- ❑ Exercise weekly
- ❑ Crave sugar
- ❑ Crave salty foods

Genitourinary
- ❑ Uterine fibroids
- ❑ Ovarian cysts
- ❑ Cancer _____
- ❑ Prostate problems
- ❑ Problems urinating
- ❑ Kidney infections
- ❑ Decrease urine flow
- ❑ Painful urination
- ❑ Frequent urination
- ❑ Incontinence

Energy /Emotion
- ❑ Fatigue
- ❑ Hyperactivity
- ❑ Restlessness
- ❑ Insomnia
- ❑ Decreased libido
- ❑ Chronic stress
- ❑ Anxiety
- ❑ Irritable
- ❑ Depression
- ❑ Low testosterone
- ❑ Memory Loss

Women's Health

- ❑ Hot flashes
- ❑ Lump in breast (R or L)
- ❑ Menopause
- ❑ Vaginal discharge
- ❑ Birth control: _____
- ❑ Are you currently on Hormone Therapy? Y N

Menstrual cycle: ☐ Regular ☐ Irregular
Pain/cramping ☐ Yes ☐ No
Length of cycle: _____ days
1st day of last period: ____ / ____ / _____
Last Mammogram / Thermography: ____ / ____ / _____
Date of last PAP: ____ / ____ / _____

Family History

- ❑ Anemia / low iron
- ❑ Asthma
- ❑ Cancer _____
- ❑ Arthritis
- ❑ Thyroid disease
- ❑ High cholesterol
- ❑ Arteriosclerosis / hardening of arteries
- ❑ Diabetes (1 or 2)
- ❑ C.O.P.D
- ❑ Neurological _____
- ❑ Heart disease
- ❑ Stroke
- ❑ Osteoporosis
- ❑ Multiple sclerosis
- ❑ Obesity
- ❑ Digestive disorders _____

Spouse, parents, brother/sister with similar health problems? _____

Lifestyle

When was your last physical exam? ____ / ____ / _____ How your day spent? Standing ____% Sitting ____% Other:

Complaint(s) interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Relationships ☐ Daily Routine ☐ Enjoying Life

Please check all options you have previously tried to assist in the above complaint(s):

- ❑ Over the counter medications
- ❑ Prescription Medication
- ❑ Dietary Changes
- ❑ Exercise
- ❑ Consult with specialist
- ❑ Supplements
- ❑ Chiropractic / Massage / Physical therapy
- ❑ Other: _____

Do you use tobacco? ☐ Yes ☐ No ☐ Previous User If yes, how often? _____
Do you drink alcohol? ☐ Yes ☐ No ☐ Previous User If yes, how often? _____
What are your health goals? _____
How do you expect to achieve these goals? _____