Evolutionary Healing Institute

6601 SW 80 Street, Suite 200A, South Miami, Florida, 33143
ph: 305.667.8174 www.ehmiami.com

New Patient Information

Date ________________________

Patient Name Last ________________________ First ________________________ MI _______________

Address ____

City ____ State ____________ Zip _________________

Sex - M_____ F_____ Age ________ Birth Date __________________ Minor____________

Married_____ Widowed______ Single_____ Separated______ Divorced_______ Partnered_______

Occupation____

Patient Employer/School____

Employer/School Address____

Employer/School Phone____

Spouse/Partner Name____ Birth Date___________________

Spouse's/Partner's Employer____

Whom may we thank for referring you?____

Contact Information

Email____ Primary Phone________________

Home Phone____________________ Work Phone__________________ Cell Phone_________________

Best time and place to reach you____

IN CASE OF EMERGENCY, CONTACT

Name_______________________________ Relationship______________ Primary Phone________________

Home Phone____________________ Work Phone__________________ Cell Phone_________________

PATIENT CONDITION

Reason for visit____

When did your symptoms first appear?____

Mark on the picture below where you continue to have pain, numbing or tingling and rate the severity of your pain according to the scale below where 1 is least pain and 10 is severe pain.

For example – if you have severe pain in the back of your neck (2nd figure) place a “10” in that box.

Extreme Pain
10
9
8
7
6
5
4
3
2
1
0
No Pain

TYPE OF PAIN

___ Sharp	___ Dull	___ Throbbing	___ Numbness
___ Aching	___ Shooting	___ Burning	___ Tingling
___ Cramps	___ Stiffness	___ Swelling	___ Other

How often do you have this pain?______________ Is it constant or does it come and go?____________________

Is this condition getting progressively worse? ___Yes ___No ___Unknown

Does it interfere with your ___Work ___Sleep ___Daily Routine ___Recreation

Activities/movements that is painful to perform ___Sitting ___Standing ___Walking ___Bending ___Lying Down

What treatment have you already received for your treatment?

___Medications ___Surgery ___Physical Therapy ___Chiropractic ___None ___Other __________________

Name and Address of other Doctor(s) who have treated you for your condition

____

____

DATE OF LAST

Physical Exam____________ Spinal X-Ray____________ Blood Test____________

Spinal Exam____________ Chest X-Ray____________ Urine Test____________

Dental X-Ray____________ MRI, CT-Scan, Bone Scan____________

HEALTH HISTORY

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	AIDS/HIV	___	___	Chicken Pox	___	___	Liver Disease	___	___	Rheumatoid Arthritis
___	___	Alcoholism	___	___	Diabetes	___	___	Measles	___	___	Rheumatic Fever
___	___	Allergy Shots	___	___	Emphysema	___	___	Migraines	___	___	Scarlet Fever
___	___	Anemia	___	___	Epilepsy	___	___	Miscarriage	___	___	Stroke
___	___	Anorexia	___	___	Fractures	___	___	Mononucleosis	___	___	Suicide Attempt
___	___	Appendicitis	___	___	Glaucoma	___	___	Multiple Sclerosis	___	___	Thyroid Problems
___	___	Arthritis	___	___	Goiter	___	___	Mumps	___	___	Tonsillitis
___	___	Asthma	___	___	Gonorrhea	___	___	Osteoporosis	___	___	Tuberculosis
___	___	Bleeding Disorders	___	___	Gout	___	___	Pacemaker	___	___	Tumors/Growths
___	___	Breast Lump	___	___	Heart Disease	___	___	Parkinson’s Disease	___	___	Typhoid Fever
___	___	Bronchitis	___	___	Hepatitis	___	___	Pinched Nerve	___	___	Ulcers
___	___	Bulimia	___	___	Hernia	___	___	Pneumonia	___	___	Vaginal Infections
___	___	Cancer	___	___	Herniated Disk	___	___	Polio	___	___	Venereal Disease
___	___	Cataracts	___	___	Herpes	___	___	Prostate Problem	___	___	Whooping Cough
___	___	Chemical Dependency	___	___	High Cholesterol	___	___	Prosthesis	___	___	Other
			___	___	Kidney Disease	___	___	Psychiatric Care			____________

ARE YOU PREGNANT? ___Yes ___No Due Date____________

INJURIES/SURGERIES YOU HAVE HAD	DESCRIPTION	DATE
Falls	____________	____________
Head Injuries	____________	____________
Broken Bones	____________	____________
Dislocations	____________	____________
Surgeries	____________	____________
	____________	____________
	____________	____________

EXERCISE	**WORK ACTIVITY**	**HABITS**	
___None	___Sitting	___Smoking	Packs/Day__________________
___Moderate	___Standing	___Alcohol	Drinks/Week_______________
___Daily	___Light Labor	___Coffee/Caffeine Drinks	Cups/Day__________________
___Heavy	___Heavy Labor	___High Stress Level	Reason_____________________

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

WHAT CHANGES WOULD YOU LIKE TO EXPERIENCE AS A RESULT OF UNIFIED THERAPY™?

Please save this form and email to ehmiami@gmail.com