

Welcome to
Evans Family Chiropractic

Thank you for choosing our office for chiropractic care. We are committed to providing your family with the highest quality of corrective and wellness chiropractic care available so that you and your family can enjoy an active, healthy life. We will be working together to help you and your family reach your health and wellness goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report and your required Wholeness Talk.

We look forward to a long, healthy relationship with you and your family.

Personal and Family Health History

Date _____

Name _____

E-mail _____

Address _____

Occupation _____

City _____ State _____ Zip _____

Employer _____

Date of Birth _____ (Age _____)

Marital Status S M D W

Phone: (H) _____

Spouse's Name _____

(C) _____ (W) _____

Spouse's Occupation _____

Referred By _____

Have you had previous chiropractic care? _____ If yes, with whom? _____

Why did you discontinue care? _____

Please Initial after reading: Life is a miracle and so are you. You deserve to be healthy. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be **interfered with** by stresses, accidents and challenges that cause disruptions in your daily life. Through your examination and your lifetime involvement in chiropractic care, **we will work to INCREASE** what is **already in you** so that you can **discover and keep** the quality of life you deserve. Thus, I neither remove nor add ANYTHING to you. _____

Number of Children and Ages

Previous Chiropractic Care?

Name _____	DOB _____	Age _____	Yes _____	No _____	Reason _____
Name _____	DOB _____	Age _____	Yes _____	No _____	Reason _____
Name _____	DOB _____	Age _____	Yes _____	No _____	Reason _____

	You	Spouse	Child#1	Child#2	Child #3	Chiropractor's Comments
Circle all that Apply						
1. Was Your Birth Traumatic?						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery?	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Fall out of bed/bunk beds?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Pulled ear/ chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs/out of tree?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
3. Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	_____
Drink?	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods)?	Y	Y	Y	Y	Y	_____
Have you been in auto accidents?	Y	Y	Y	Y	Y	_____
Have you had surgery/augmentation?						_____
organs replaced/removed (tonsils, uterine)?	Y	Y	Y	Y	Y	_____
Drugs (Prescriptive or Non-Prescriptive)?	Y	Y	Y	Y	Y	_____
Have Teeth Problems?	Y	Y	Y	Y	Y	_____
Have Eye Problems?	Y	Y	Y	Y	Y	_____
Have Hearing Problems?	Y	Y	Y	Y	Y	_____

Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	_____
Have occupational stress ?	Y	Y	Y	Y	Y	_____
Have physical stress ?	Y	Y	Y	Y	Y	_____
Have mental stress ?	Y	Y	Y	Y	Y	_____
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

Current Health Condition

Present Complaint (be brief) Reason For Your Visit Today

Major _____

Pain or Problem started on _____

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition **getting progressively worse**? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Females: Are you pregnant? _____

Other symptoms:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Fainting | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Buzzing in Ear |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Smell | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Taste | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Diarrhea | |

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? _____ What? _____ When? _____

What effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

After the first visit, you will schedule a Chiropractic Report to discuss the different types of Wholeness Plans that are available to you. Wholeness Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of **your** health goals.

How committed are you to your health? 1. Not at all. 2. Somewhat concerned. 3. Very important to me!

As a result of my chiropractic care, I would like to... (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Only feel better and return with the pain | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

What do you expect to happen as a result of your care? _____

If you found out that you had a condition chiropractic could help you with what would you do? _____

Person responsible for payment _____ (**Payment is expected at the time of service.**)

Member Signature

Date

Doctor signature

Evans Family Chiropractic

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of pain, disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

(signature)

(date)

Evans Family Chiropractic

Office Fee Schedule and Financial Policy

<u>Service</u>	<u>Investment</u>
Consultation	\$0-80
Initial Assessment	\$45-95
Follow up Assessment	\$35
Adjustment	\$40
Therapy	\$30-50
Extended Visit or After Hours	\$85
Wholeness Adjustment Plans	available

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time service is rendered unless you arrange a Wholeness Plan. Wholeness Plans include yearly, monthly, weekly, or extended payment plans. These Wholeness Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. On your second visit, details of these plans will be discussed with you during your Chiropractic Report.

Insurance: I only have your best health in mind. I work for YOU not insurance companies. My loyalty is to YOU. If you have insurance that covers chiropractic, we will give you all of the information you need to get reimbursed. We have found it is easier for your record keeping, and ours, if we give you receipts at the end of your first visit and then once a month after that. Just send in your receipts with a copy of your claim form and your insurance company should communicate with you about your reimbursement. If you are here as a result of an auto collision, there is a possibility to file insurance. Understand you are responsible for any care received yet denied by insurance. They have no obligation to me. Remember, your agreement with your insurance company is between you and them.

For your comfort we will be answering questions and discussing the financial choices at the Chiropractic Report. Bring all information, people and questions with you so we can answer them and be clear and confident about your health options.

I have read and I understand the above policies.

Signature

Date