



EVOLUTIONARY HEALING INSTITUTE

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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

- | | | | |
|---------------------------------|------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Shooting | <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Swelling | <input type="checkbox"/> 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 _____

EXERCISE

___ None
___ Moderate
___ Daily
___ Heavy

WORK ACTIVITY

___ Sitting
___ Standing
___ Light Labor
___ Heavy Labor

HABITS

___ Smoking
___ Alcohol
___ Coffee/Caffeine Drinks
___ High Stress Level

Packs/Day _____
Drinks/Week _____
Cups/Day _____
Reason _____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

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

**Please save this form, adding your name at the end of the file name, and email to
ehmiami@gmail.com**