

EVOLUTIONARY HEALING INSTITUTE

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New Patient Information

Date							
PATIENT NAME LAST	First	MI					
Address							
Сіту	State	ZIP					
Sex - M F Age	BIRTH DATE	MINOR					
Married Widowed S	INGLE SEPARATED	Divorced Partnered					
Occupation							
Patient Employer/School							
Employer/School Address							
Employer/School Phone							
Spouse/Partner NameBirth Date							
SPOUSE'S/PARTNER'S EMPLOYER							
WHOM MAY WE THANK FOR REFERRING YOU?							
CONTACT INFORMATION							
Email		PRIMARY PHONE					
Номе Рноме	Work Phone	Cell Phone					
BEST TIME AND PLACE TO REACH YOU							
IN CASE OF EMERGENCY, CONTACT							
Name	RELATIONSHIP	PRIMARY PHONE					
Номе Рноле	Work Phone	Cell Phone					

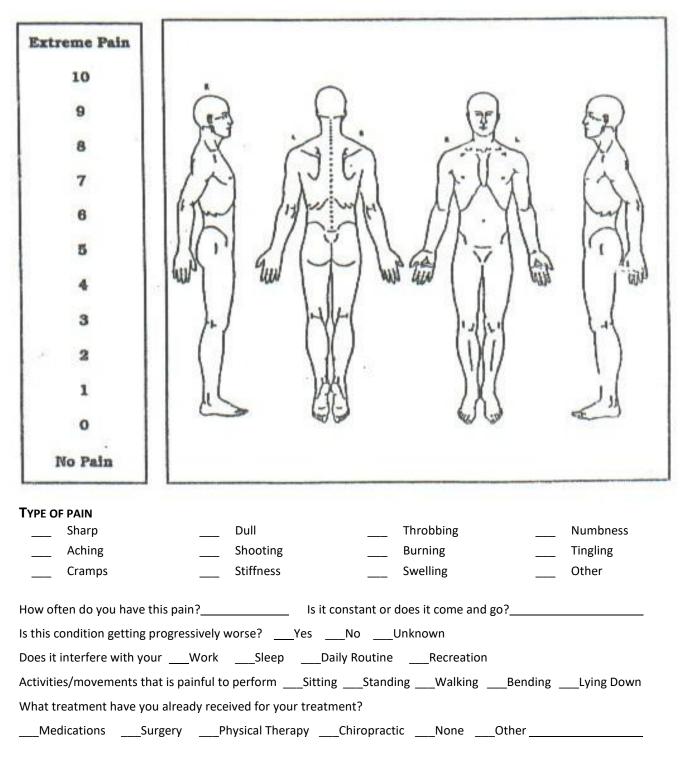
PATIENT CONDITION

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.



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

Date of Last				
Physical Exam	Spinal X-Ray_	Blo	od Test	
Spinal Exam	Chest X-Ray	Uriı	ne Test	
Dental X-Ray	MRI, CT-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	High Cholesterol	Prosthesis	Other	
Dependency	Kidney Disease	Psychiatric Care		
ARE YOU PREGNANT?	esNo Due Date	2		
INJURIES/SURGERIES YOU HA	VE 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
<u>Medications</u>	<u>Allergi</u>	<u>ES</u>	/itamins/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