Evolution Medical Associates

604 Druid Rd. E. Clearwater, FL 33756 727-216-3492

We're delighted you're here! Who can we thank?

Dr referral: ______________________ **Friend/Family name:** ________________________

Our Website: ____ **Facebook:** ___ **Yelp:** ___ **Twitter:** ___ **Pinterest:** ___ **GOOGLE:** ____ **Other:** ______

Patient #_____________ (Office Use Only) If expecting, Due Date: ____________________

Date of Appointment: _____________ **Time:** __________ **Appt w/**____________________

Mr. Mrs. Miss Ms. Dr. **Preferred/Nickname:** _________________ Birth Date: ____________

(Please PRINT) Please Circle: Female / Male Marital Status: S M W D P

Name: ____

Address: ____ _____________ City, State, **Zip**: ________________________________

Occupation: _______________________ Employer: ______________________________________

SS#: _____________________________ E-Mail: ____

*SS# optional for identification; **ONLY required for VA*** **PLEASE PRINT** - *Email address required for email appt reminder*

____

Home Phone Number: (______)______________ Cell Phone: (______)_________________

Cell Phone number required for text appt reminder

Work Phone Number: (______)______________ ****Best Way to Reach You**: Home Cell Work

Emergency Contact: ____

(Name, relationship & phone number with area code)

Please Circle Your Appointment Reminder Preference: Text / Email / None

Primary Physician's Name: _________________________ PCP's Phone: ___________________

Referring Doctor's Name: __________________________ Dr.'s Phone #: __________________

Doctor's Address: ________________________________ Dr.'s FAX #: ____________________

MY PAYMENT METHOD: (Please circle ONE)

Acupuncture - **CASH** **MC (LBP)** **Veterans Administration**

Cash Payment will be made when treatment is rendered. Detailed receipts are available.
Cash; Check; FSA/HSA cards *or* Credit/Debit cards (Visa; Master Card; American Express or Discover)

Privacy Statement: Your information will be shared only with your doctors and other healthcare practitioners directly involved in your care. If using FSA/HSA cards, information will be sent to insurers as requested. Full HIPAA forms available upon request. Rev. 8.1.19

If you have arranged for a treatment package, please be sure to complete and sign our Evolution Medical Associates Financial Policy.

Date: ______________________________ Patient #____________ **(Office Use Only)**

NAME: ____ Date of Birth______________

Have you had acupuncture before? ____________ Chinese herbal medicine? ____________

Issue of greatest concern for you today: ____

How does this issue interfere with your daily activities (work, sleep, diet, etc)?

____

How long has it been since you first noticed symptoms: ______________________________

Is it getting worse? _________________ Or is it simply persistent? _________________

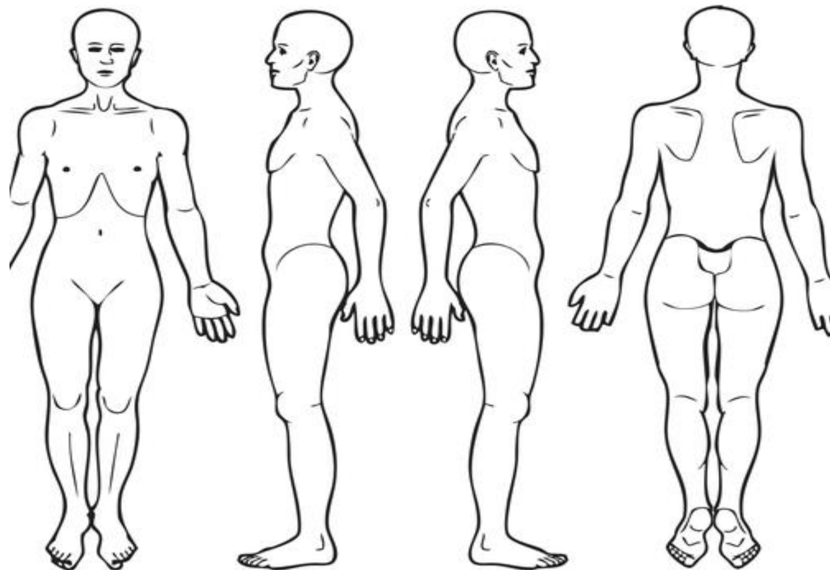
What seemed to be the initial cause? ____

What makes it better? ______________________ Worse? ___________________________

If you've been given a diagnosis by your family physician, what is it? __________________________

What treatments or therapies have you tried? ____

PLEASE CIRCLE OR "X" AREAS OF PAIN OR DISTRESS:



Please circle pain level today: **10 9 8 7 6 5 4 3 2 1 0**

(10 = Worst imaginable 5 = Barely tolerable without medicine 1 = No problem)

FAMILY MEDICAL HISTORY: (Please circle)

Allergies _______________	_________________	_____________________
Arteriosclerosis	Asthma	Alcoholism
Cancer _________________	__________________	______________________
Depression	Diabetes ___________	Heart Disease
High Blood Pressure	Seizures	Stroke

Date: ______________________________ Patient #____________ **(Office Use Only)**

NAME: ______________________________________ Date of Birth______________

***YOUR* PAST MEDICAL HISTORY: (Please circle. Please note dates)**

Alcoholism	Allergies	Appendicitis	Arteriosclerosis
Asthma	Birth Trauma (your birth)		Cancer
Chicken Pox	Diabetes	Emphysema	Epilepsy
Goiter	Gout	Heart Disease	Hepatitis
Herpes (type)	High Blood Pressure	HIV/AIDS	Measles
Multiple Sclerosis	Mumps	Pacemaker (date)	Pleurisy
Pneumonia	Polio	Rheumatic fever	Scarlet fever
Seizures	Stroke	Thyroid Disease	Tuberculosis
Typhoid Fever	Ulcers	Venereal disease	Whooping Cough

Major illness, Accidents, surgeries, or significant trauma: ________________________

LIFESTYLE: (Please circle)

Current medication/supplements? ____

Please indicate usage per day/per week:

Alcohol	Caffeine	Cigarettes/Tobacco	Drugs
Marijuana	Sugar	Other ____________________________	

Occupational Hazards: ____

Regular Exercise: ______________________ Frequency: _______________

Are you on a special diet? _________ Please specify: __________________

CIRCLE any condition(s) you have experienced within the last (3) three months. Indicate the length of time you have had this condition.

GENERAL:

Appetite/Changed	Appetite/Heavy	Appetite/Poor
Artificial Sweeteners	Bleed/bruise easily	Chills
Coffee/Tea	Cold hands/feet	Cravings
Disturbed sleep	Edema	Fatigue
Fever	Fruit Juices	Insomnia
Muscle cramps	Night Sweats	Poor Balance
Poor Circulation	Salty Foods	Shortness of breath
Soft Drinks	Sudden energy drop (time of day)	
Sugar	Sweat easily	Thirst
Tremors	Vertigo/Dizziness	Weakness/localized
Weight loss/gain		

Date: ______________________________ Patient #____________ **(Office Use Only)**

NAME: ______________________________________ Date of Birth______________

Peculiar taste _____________ Protein Intake: Low _____ High ______

Thirst for water: # of glasses per day ___________________________________

Other unusual conditions: ____

SKIN AND HAIR (Please circle)

Acne	Dandruff	Eczema	Fungal Infections
Hair Loss	Hives	Itching	Moles
Psoriasis	Rashes	Ulcerations	

Changes in hair or skin texture, acne ____________________________________

Any other hair or skin problems: ____

HEAD, EYES, EARS, NOSE, THROAT (Please circle)

Change in taste	Concussions	Dizziness	Dry Mouth
Excessive Saliva	Facial Pain	Grinding teeth	Gum problems
Headaches	Jaw clicks	Migraines	Sinus problems
Swollen Glands	TMJ		

Blurred Vision	Cataracts	Dry eyes	Eye pain
Eye Strain	Glasses {age ____________}		Glaucoma
Itchy Eyes	Night blindness	Poor vision	Red Eyes
Spots in eyes			

Earaches Poor Hearing

Ear ringing, Hearing loss (where? _____ when? _____)

Nosebleeds

Excessive phlegm	Enlarged thyroid	Lumps in Throat	Recurrent sore throat
Sores on tongue/lips			

Any other head or neck problems: _______________________________________

Date: ______________________________ Patient #______________ **(Office Use Only)**

NAME: ____ Date of Birth______________

CARDIOVASCULAR AND RESPITORY (Please circle)

Asthma	Blood clots	Bronchitis
Chest pain	Cold hands/feet	Cough, blood
Cough, dry	Cough, wet	Difficulty breathing
Dizziness	Excessive phlegm (color: __________)	Fainting
Heart palpitations	High blood pressure	Irreg heartbeat/Afib
Low blood pressure	Phlebitis	Pneumonia
Shortness of breath	Swelling of feet	Swelling of hands
Tachycardia	Tight chest	Wheezing

GASTROINTESTINAL (Please circle)

Acid regurgitation	Abdominal Cramps	Abdominal Pain
Anal Burning	Anal Fissures	Anal itching
Bad Breath	Belching	Black Stools
Bloating	Blood in stool	Constipation
Diarrhea	Gas	Hemorrhoids
Hiccup	Indigestion	Nausea/Vomiting
Mucous in stools	Rectal Pain	Intestinal pain/cramps
Laxative use? _____	How often? __________	What kind?________________

Bowel movements: Frequency ________________ Color ________________

GENITOURINARY AND REPRODUCTIVE (Please circle)

Bedwetting	Blood in urine	Decrease in flow
Frequent urination	Incomplete Urination	Kidney stones
Pain on urination	Sores on genitals	Urgent urination
Unable to hold urine	Wake to urinate	*Other problems*?

Do you wake up at night to urinate? __________ If so, how often? ____________

Any particular color to your urine? ____________ Other problems? ___________

Venereal disease: ________________________ Change in sex drive

Impotence Premature ejaculation Nocturnal emission

Date: ______________________________ Patient #____________ **(Office Use Only)**

NAME: ____ Date of Birth______________

GENITOURINARY AND REPRODUCTIVE (continued)

Length of cycle (day 1 – day 1) _______________ Duration __________ days

First day of last menses _________________ PMS ___________________

Premenstrual changes Heavy/Irregular/Light menses Miscarriages

Painful menses Unusual menses Abortions Clots

Are you pregnant, or trying?_____ Date of last PAP test ____________

Age at first menses _____ Age at menopause _____

Breast lumps _______________ Number of pregnancies ________

Number of live births________ Number of premature births ________

Do you practice birth control? If so, what type? _______________________

For how long _____ Vaginal discharge ______ (color) _______

Vaginal sores ______________ Vaginal odor _________________________

MUSCULOSKELETAL (Please circle)

Back pain Foot/ankle pain Hand/wrist pain Hip pain

Joint pain Knee pain Muscle weakness Neck pain

Numbness Rib Pain Shoulder pain

Limited range of motion/use: ____

Any other problems: ____

NEUROPSYCHOLOGICAL (Please circle)

Abuse Survivor Anxiety Bad temper Depression

Easily stressed Irritability Lack of coordination

Numbness Poor memory Seeing a therapist

Seizures Sleep Problems Tics

Have you ever been treated for emotional problems? ________________________

Have you ever considered or attempted suicide? ____________________________

Any other neurological or psychological problems? __________________________

____

Please list any other problems you would like to discuss: _____________________

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, ______________________ (Name of Patient), hereby voluntarily authorize the disclosure of information from my health record.

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY Evolution Medical Associate (Phone: 727/216-3492)
ADDRESS	ADDRESS 604 Druid Road E (Fax: 727/216-3495)
CITY/STATE	CITY/STATE Clearwater, FL 33756

III. The purpose or need for this disclosure is:

- ☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* ______________________
- ☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other ______________________)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

- ☐ Only information related to *(specify)* ______________________
- ☐ Only the period of events from ______________________ to ______________________
- ☐ Other *(specify) (CHS, Billing, etc.)* ______________________
- ☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
- ☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
- ☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION	NAME *(Last, First, MI)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH

Evolution Medical Associates

604 Druid Rd. E. Clearwater, FL 33756 727-216-3492

AUTHORIZATION for RELEASE OF INFORMATION

for USE, COPYING, DISCLOSURE and INSPECTING of PROTECTED HEALTH INFORMATION

PATIENT NAME: ____

DATE of BIRTH: ______________________ SOCIAL SECURITY NUMBER: _______________________________

1. I hereby authorize ____ (hereinafter "Medical Provider") to use, copy, disclose or allow inspection of protected health information about me as described below. A photocopy of this authorization is as valid as an original.

2. The information to be disclosed is for all dates of service requested and includes:
   _____ Complete medical records, including but not limited to, office notes, progress notes, procedure notes, operative reports, intake questionnaire and patient history form
   _____ Physical therapy records _____ Massage therapy records _____ Billing records
   _____ Benefits information, incl health insurance, workers' compensation, Medicare, Medicaid, and disability coverage
   _____ Other: ____

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse: or mental or behavioral health or psychiatric care.
4. I understand that copies of the records indicated above may be sent to my attorneys, ____________________________ as said records are needed to assist in their representation on my behalf.
5. I understand that the information used or disclosed may be subject to re-disclosure by the Law Office of _______________________ and would then no longer be protected by federal or state privacy regulations.
6. I understand that I may revoke this authorization by notifying the Medical Provider in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. Unless otherwise revoked, I understand that this authorization expires on ___________________________.
8. I understand that the Medical Provider may not condition treatment on my completion of this authorization form.
9. I understand that the Medical Provider may charge a fee for the costs of copying, mailing or supplying the requested information.

I, _______________________________________, hereby give consent for agents of Evolution Medical Associates LLC to release specified information to and discuss issues regarding me with the people and entities listed below:

________________________________	____________________________	________________________
Printed Name	**Printed Name**	**Printed Name**

____ ________________________________

Signature of Patient or Parent, Guardian or Personal Representative **Date**