12841 Jones Road
Suite 250
Houston, Tx 77070

Phone: 281-231-8777
Fax: 713-903-7956
Email: JM@evolutionheal.com

EVOLUTION
HEALTH & WELLNESS
HEALING ALL PIECES OF THE PUZZLE
MIND. BODY. SOUL

Adult New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Preferred Name: _____ Preferred Pronoun: _____ Sex (as listed on insurance card): _____

Home Phone: _____ Mobile Phone: _____

Preferred Phone: Home or Mobile (circle one) Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ Employer: _____

Primary Care Provider (PCP): _____ PCP Phone: _____

Referring Provider: _____ Referring Phone: _____

Preferred Pharmacy: _____ Pharm Phone: _____

Preferred Pharmacy Address: _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc…) Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

Decline Response ☐
Hispanic or Latino ☐
Not Hispanic or Latino ☐

Race:

Decline Response ☐
American-Indian or Alaska Native ☐
Asian ☐
Black or African American ☐
Native Hawaiian or Pacific Islander ☐
White ☐
Other ☐

Preferred Language: Decline Response ☐

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Evolution Health & Wellness for services rendered. I authorize representatives of Evolution Health & Wellness to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient Notice of Privacy Practices: Acknowledgment of Receipt

I acknowledge that I was provided with a copy of the Evolution Health & Wellness Notice of Privacy Practices (NOPP).
☐ Received ☐ N/A (only if you received the notice from Evolution Health & Wellness previously)

Information Disclosure and Consent

Evolution Health & Wellness will provide you with the health plans that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____ Date: _____

Please request superbill from provider for insurance purposes.

Reason for today's visit:

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems	□ Y	□ N	Heart Disease/Disorder	□ Y	□ N
Arthritis	□ Y	□ N	Lung Disorder	□ Y	□ N
Bleeding/Clotting Disorder	□ Y	□ N	Liver Disease	□ Y	□ N
Blood Pressure Disorder	□ Y	□ N	Neurological Disorder/Chronic Headaches	□ Y	□ N
Blood Transfusion	□ Y	□ N	Psychiatric Disorder/Illness	□ Y	□ N
Bowel/Stomach Problems	□ Y	□ N	Pulmonary Embolism/DVT	□ Y	□ N
Cancer	□ Y	□ N	Stroke	□ Y	□ N
Cholesterol Disorder	□ Y	□ N	Seizure or Epilepsy	□ Y	□ N
Diabetes	□ Y	□ N	Thyroid Disorder	□ Y	□ N
Eye Disorder (i.e. Glaucoma, cataract)	□ Y	□ N	Urinary/Kidney Disorder	□ Y	□ N
If Relevant: Gynecological Issues	□ Y	□ N			

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	

Social History

Do you currently smoke? □ Yes □ No If no, previously? □ Yes □ No Years smoked _____ Packs/ day _____

Do you use other tobacco products? □ Yes □ No Consume alcohol? □ Y □ N If yes, drinks/ week: _____

Patient Reproductive/ Sexual Health

Are you sexually active? □ Yes □ No

Do you consider yourself to be? □ Heterosexual or straight □ Gay or lesbian □ Bisexual
□ Not listed, please state: _____

What sex were you assigned at birth? □ Male □ Female

Current gender identity? □ Male □ Female □ Transgender Male/Trans man
□ Transgender Female/ Trans woman □ Genderqueer/non-binary
□ Other, please state:_____

In the past year, have you had sex with? □ Men only □ Women only □ Both men and women □ Not listed, please state: _____ □ I have not had sex

Have you had any sexually transmitted diseases? □ Yes □ No

Would you like to be tested for HIV? □ Yes □ No

If relevant: Date of your last menstruation or age of menopause _____

Last Pap Smear _____ Last mammography _____

If relevant: Any past pregnancies? □ Yes □No How many? ___ How many deliveries? ____

Do you have any discharge from or lumps in your breast or chest? □ Yes □ No

If relevant: Do you have sores or lumps on your penis or testicles? □ Yes □ No

Functional Assessment

Do you use any equipment (such as a walker or wheelchair) to assist in your daily life?
□ Yes □ No If yes, what? _____

□ Yes □ No

Have you fallen in the past 6 months? □ Yes □ No

Do you have difficulty with balance or walking? □ Yes □ No

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose

Medication Name	Dose

EVOLUTION HEALTH & WELLNESS

Review of Systems Please indicate ALL that you have experienced within the past 6 – 12 months.

Constitutional

Fever	□Y□N	Sweats	□Y□N	Unexplained Weight Change	□Y□N
Chills	□Y□N	Weight Gain (___ Lbs)	□Y□N	Trouble Sleeping	□Y□N
Fatigue	□Y□N	Weight Loss (___ Lbs)	□Y□N	□ Other:	
Feeling Poorly	□Y□N				

Head, Eyes, Ears, Nose, and Throat

Vision Problem	□Y□N	Eye Pain	□Y□N	Snoring	□Y□N	Ringing in Ears	□Y□N
Double Vision	□Y□N	Runny Nose	□Y□N	Dry Mouth	□Y□N	Vertigo	□Y□N
Light Sensitivity	□Y□N	Neck Stiffness	□Y□N	Flu-Like Symptoms	□Y□N	Earache	□Y□N
Itchy Eyes	□Y□N	Nosebleed	□Y□N	Sore Throat	□Y□N	Hearing Loss	□Y□N
Red Eyes	□Y□N	Congestion	□Y□N	Hoarseness	□Y□N	□ Other:	

Cardiovascular

Chest Pain	□Y□N	Cold Hands or Feet	□Y□N	□ Other:	
Palpitations	□Y□N	Leg Pain w/ Walking	□Y□N		
Leg Swelling	□Y□N	Irregular Heart Rhythm	□Y□N		

Respiratory

Shortness of Breath	□Y□N	Wheezing	□Y□N	Coughing Up Mucus	□Y□N		
Cough	□Y□N	Chest Congestion	□Y□N	□ Other:			
Rapid Breathing	□Y□N	Coughing Up Blood	□Y□N				

Gastrointestinal

Abdominal Pain	□Y□N	Diarrhea	□Y□N	Change in Bowels	□Y□N	Painful Swallowing	□Y□N
Blood in Stool	□Y□N	Black/Tarry Stools	□Y□N	Vomiting Blood	□Y□N	□ Other:	
Vomiting	□Y□N	Decreased Appetite	□Y□N	Bowel Incontinence	□Y□N		
Nausea	□Y□N	Yellow Skin	□Y□N	Rectal Pain	□Y□N		
Constipation	□Y□N	Trouble Swallowing	□Y□N	Heartburn	□Y□N		

Neurological

Headache	□Y□N	Unsteady	□Y□N	Numbness	□Y□N	Tremor	□Y□N
Dizziness	□Y□N	Disorientation	□Y□N	Tingling	□Y□N	Memory Lapses/Loss	□Y□N
Decreased Strength	□Y□N	Confusion	□Y□N	Seizures	□Y□N	□ Other:	
Poor Coordination	□Y□N	Burning Sensation	□Y□N	Fainting (Syncope)	□Y□N		

Musculoskeletal

Joint Pain	□Y□N	Limb Pain	□Y□N	Muscle Pain	□Y□N	□ Other:	
Neck Pain	□Y□N	Joint Swelling	□Y□N	Muscle Weakness	□Y□N		
Back Pain	□Y□N	Muscle Cramps	□Y□N	Leg Swelling	□Y□N		

Genitourinary

Frequent Urination	□Y□N	Pelvic Pain	□Y□N	Change in Libido	□Y□N	Irreg. Monthly Cycles	□Y□N
Incontinence	□Y□N	Urinating during the night	□Y□N	Painful Intercourse	□Y□N	Heavy Period Bleeding	□Y□N
Urinary Urgency	□Y□N	Itching- Genital	□Y□N	Discharge- Vaginal	□Y□N	□ Other:	
Painful Urination	□Y□N			Vaginal Bleeding	□Y□N		

Integumentary

Rash	□Y□N	Skin Wound	□Y□N	Unusual Growth	□Y□N	Skin Cancer	□Y□N
Dry Skin	□Y□N	Change in A Mole	□Y□N	Itching	□Y□N	□ Other:	

Psychiatric

Depression	□Y□N	Anxiety	□Y□N	□Other:

Hematologic/Lymphatic

Easy Bruising	□Y□N	Easy Bleeding	□Y□N	Swollen Lymph Nodes	□Y□N	□ Other:	

Endocrine

Excessive Thirst	□Y□N	Heat Intolerance	□Y□N	Changes- Skin	□Y□N
Cold Intolerance	□Y□N	Changes- Hair	□Y□N	□ Other:	