UNLIMITED HEALTH CHIROPRACTIC

Patient Information & History

Date:_____

1 PATIENT INFORMATION

Name: _____
(First) (Initial) (Last) (Name called by)

Address: _____

_____

Birthday: _____Age: ____ ☐ Male ☐ Female

Social Security # _____/_____/_____

Occupation: _____

Employer: _____

Parents Name(if a minor):_____

☐Single ☐Married ☐Divorced ☐Widowed ☐Seperated

Spouse's Name: _____

# of Children: ___Name(s)_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to patient_____

Insurance company_____

Insurance ID number_____

Group / Claim number_____

Is patient covered by additional insurance? ☐Yes ☐No

Insurance company_____

Subscriber # and name_____

Birthdate_____Group #_____

Please present insurance card(s) so we can put a copy in your file.

3 ACCIDENT INFORMATION

Is your condition due to an accident? ☐ No ☐ Yes Date: _____

Type of accident? ☐ Automobile ☐ Work ☐ Home ☐ Other

To whom have you reported the accident?

Insurance ☐ Worker's Comp ☐ Employer ☐ Other_____

Attorney Name (If applicable)_____

4 CONTACT INFORMATION

Home phone_____

Cell phone_____

Work Phone_____Ext_____

Email_____

Best way to reach you ☐ Home ☐ Cell ☐ Work ☐ Email

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____

Home Phone_____Cell_____

5 PATIENT CONDITION

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? Yes ☐ No ☐

Is this problem: ☐ constant ☐ comes and goes

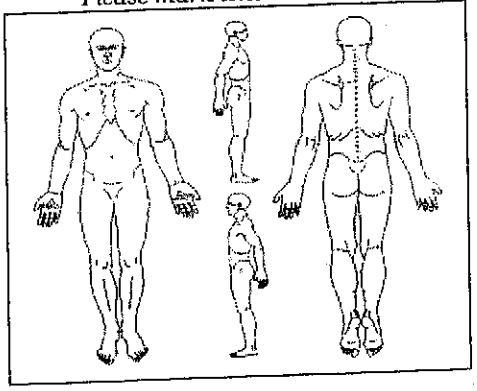
How does it Feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Aching ☐ Stiff

☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other_____

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)

Please mark where it hurts



What makes your condition better? _____

What makes your condition worse? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Driving ☐ Reading ☐ Getting Up

- Please continue on the back -