Every Spine Chiropractic

Dr. Jeremy Ungerank
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Cabot, AR 72023
(501) 286-7726

Office Use only:

CC: _____.

_____.

Res: _____.

Information Sheet

Patient Name:_____ Male or Female Today's date:_____

Birthdate:_____ Age:_____ SSN#_____

Mailing Address:_____

_____

City State Zip

Home phone #:_____ Work phone #:_____

Cell phone #:_____ Email Address:_____

Employer:_____ Occupation:_____ How Long:_____

Employer's Address:_____

_____

City State Zip

Marital Status (please circle one): Minor Single Married Divorced Separated Widowed

Spouse's Name:_____ Do you have children (please circle one)? Y or N How many:_____

In Case of Emergency

Who should we contact? _____ Relation to you: _____

Home Phone #: _____ Work Phone #: _____

Cell phone #: _____

Who is your Medical Doctor? _____ M.D.'s Phone #: _____

Insurance Information

Primary Insurance:

Co. Name: _____ Insured's Employer: _____

Address: _____

_____

City State Zip

Phone #: _____ Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____ Date of Birth: _____

Insured's Name: _____ Relation: _____

Secondary Insurance:

Co. Name: _____ Insured's Employer: _____

Address: _____

_____

City State Zip

Phone #: _____ Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____ Date of Birth: _____

Insured's Name: _____ Relation: _____

Reason for Visit

Reason for today's Visit (please Circle one): Emergency, New Injury, Old Injury, Chronic pain, Wellness

Are you in pain: YES or NO Rate your pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Intense pain)

Did your injury occur during: Work, Sports/play, Auto Accident, Routine/household activity

When did your condition/accident occur? (Date) _____

Where did your injury occur? _____

Please explain what happened: _____

_____

Is your condition getting worse? YES, NO, Constant, or Comes and goes

Is your condition interfering with your Work, Sleep, or Daily routine? If so please explain:_____

_____

_____

Have you ever had this condition before? YES or NO Explain: _____

_____

Using the adjacent body charts, please circle all affected areas

Have you been treated by a Medical Physician for this condition?

YES OR NO If so by whom and where? _____

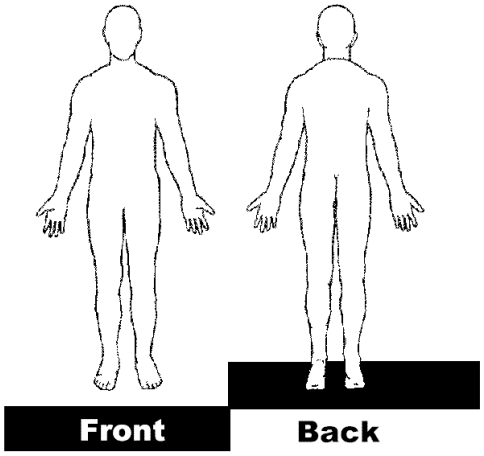
_____

_____

Have you ever been treated by a Chiropractor? YES or NO

Clinic or Dr's name: _____

Clinic phone#:_____



Health History

Are you taking any of the folowing medications (please circle if applies)? Nerve pills,

Pain Killers (including aspirin), Muscle relaxers, Blood Thinners, Tranquilizers, Insulin

Other(s)_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y/N Heart Attack/ Stroke	**Y/N Heart Surg./Pacemaker**	**Y/N Heart Murmur**	**Y/N Cong. Hrt Defect**
Y/N Mitral Valve Prolapse	**Y/N Artificial Valves**	**Y/N Veneral Disease**	**Y/N Hepatitis**
Y/N Alcohol/Drug Abuse	**Y/N HIV+/AIDS/ARC**	**Y/N Shingles**	**Y/N Cancer**
Y/N Frequent Neck Pain	**Y/N Glaucoma**	**Y/N Anemia**	**Y/N Diabetes**
Y/N High/Low Blood Pressure	**Y/N Psychiatric Problems**	**Y/N Rheumatic fever**	**Y/N Headaches**
Y/N Kidney Problems	**Y/N Ulcers/Colitis**	**Y/N Sinus Problems**	**Y/N Tuberculosis**
Y/N Fainting/Seizures/Epilepsy	**Y/N Emphysema/Asthma**	**Y/N Difficulty Breathing**	**Y/N Chemotherapy**
Y/N Low Back Problems	**Y/N Artificial Bones/Joints**	**Y/N Arthritis**	

Please List an surgeries with dates and/or any other serious medical contition(s) not listed above:

_____

_____

List any past serious accidents with dates:_____

_____

Please list anything that you may be allergic to:_____

Family Health History:_____

Do you take Supplements or Vitamins? Y/N Do you Exercise? Y/N Hours/week_____

Do you smoke? Y/N How much?_____ How Long?_____

For Women: Are you taking Birth Control? Y/N Are you Pregnant? Y/N Are you Nursing? Y/N

Signature:_____ Parent/guardian:_____