UNIFIED HEALTH

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Law Office:		Date of Injury:	
Attorney:		Marital Status: ☐ S ☐ M ☐ W	
Address:			
City:	State:	Zip Code:	
Home Phone:	Work Phone:	Cell Phone:	Email:

Race		
☐ American Indian or Alaska Native	☐ Guamanian or Chamorro	☐ Samoan
☐ Asian	☐ Korean	☐ Vietnamese
☐ Black or African American	☐ Other Asian (ex: Hmong, Laotian, Thai)	☐ White
☐ Chinese	☐ Other Pacific Islander (ex: Fijian, Tongan)	☐ Decline to Disclose
☐ Filipino	☐ Other Race	

Ethnicity		
☐ Not Hispanic or Latino	☐ Hispanic or Latino (please choose below)	☐ Chicano
☐ Unknown	☐ Mexican	☐ Puerto Rican
☐ Decline to Disclose	☐ Mexican American	

Preferred Pharmacy:		Phone Number:
Cross Streets:	City:	Zip Code:

PERSONAL INJURY MEDICAL QUESTIONNAIRE

Please write a complete history of your injury.

How did your injury happen?	
What body parts were affected?	
What actions were taken?	

Associated Symptoms (Pain, Itch, Etc.)	
1.	Severity: 1 2 3 4 5 6 7 8 9 10
2.	Severity: 1 2 3 4 5 6 7 8 9 10
3.	Severity: 1 2 3 4 5 6 7 8 9 10
4.	Severity: 1 2 3 4 5 6 7 8 9 10
5.	Severity: 1 2 3 4 5 6 7 8 9 10

What types of medical treatment have you received?	

Previous Treatments					
1.	Effectiveness: ☐ None	☐ Poor	☐ Fair	☐ Good	
2.	Effectiveness: ☐ None	☐ Poor	☐ Fair	☐ Good	
3.	Effectiveness: ☐ None	☐ Poor	☐ Fair	☐ Good	

Current Condition			
Has your condition improved or continues the same?	☐ Improved	☐ Same	☐ Worse
Do you currently have any complaints or symptoms?			
Does the injury affect your activities of daily living? (Please check the box that applies to you).	☐ Maintaining your personal hygiene (bathing, combing hair etc.) ☐ Daily house work ☐ Driving a car ☐ Sleep ☐ Work performance		
Please explain why the activities mentioned above affect your daily living:			
Has the injury caused any changes to your physical appearance?	☐ Yes	☐ No	
If you answered yes, has the change caused you any embarrassment?			
In a brief sentence, please indicate how the injury has affected you emotionally and/or physically.			

My General Health is: ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Acne Problems	☐ Yes	☐ No
Chest Rash	☐ Yes	☐ No
Discoloration / Stretch Marks	☐ Yes	☐ No
Dry Skin / Itchy Skin	☐ Yes	☐ No
Recent Illness / Weight Loss / Weight Gain	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Skin Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Other:	☐ Yes	☐ No

Do you smoke now? In the past?		
Do you drink? In the past?		
Are you currently pregnant?	☐ Yes	☐ No
Are you currently breastfeeding?	☐ Yes	☐ No
Allergies (Please include all) with Symptoms of Allergies		

CONSENT FOR EVALUATION AND TREATMENT

I consent to medical treatment from Unified Health Care Inc., its affiliates, physicians, and employees. Treatment may include any necessary examination, test, or medical procedures ordered by the physician(s) to be performed by Unified Health Care Inc. staff. I understand I may refuse treatment at any time.

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our office has copies of the HIPPA Notice of Privacy Practices available. Please feel free to get a copy or ask a staff member to hand one to you. My signature below indicates I have read and understand the full Notice of Privacy Practices.

ACKNOWLEDGEMENT: MISSED APPOINTMENT / NO SHOW FOR PATIENTS

Please notify our office two weeks in advance if you are unable to keep your scheduled appointment. If you do not notify us and miss your appointment, it counts as a no show. My signature below indicates I understand the missed appointment policy.

Patient Name: ____

Signature: ___________________________ Date: __________________________