PATIENT INFORMATION

For Office use Only
Patient #

Patient's First Name_____ Middle_____ Last_____ Date _____

Address _____ City _____ Zip Code _____

Home Phone _____ Cell Phone_____

E-mail _____ Social Security # _____

Employer Name _____

Job Title _____ Work Phone # _____

Date of Birth _____ Age____ Gender ___Male ___Female Handedness? R L

Weight_____ Height _____ Marital Status S M W D

Spouse's Name_____ Spouse's Date of Birth _____

Person responsible for this account_____

Health Insurance Company _____ Phone number_____

Policy/Member ID #_____ Group #_____

Address _____ City _____ Zip Code _____

Adjuster _____ Phone Number _____

Name of the insurance card holder_____

Social Security # of card holder _____

Name of their employer_____ Employer Phone #_____

Children names and ages_____

Car Insurance Company _____

Address _____ City _____ Zip Code _____

Adjuster _____ Phone #_____

Agent _____ Phone # _____

Policy # _____ Claim # _____

Drivers License # _____

Name of Insured on your Car Policy _____ Date of Loss/Accident? _____

Medical Coverage? _____ Uninsured Motorist Coverage? _____

Underinsured Motorist Coverage?_____

Personal Injury Protection (PIP) Y N $_____

Medical expenses to date as a result of the accident? $_____

Lost wages since accident $_____

What is the repair amount of your car? $ _____

Lawyer/ Law Firm_____ Phone #_____

Address _____City _____Zip Code _____

In case of emergency, whom should we contact? _____

Phone #_____

Family physician_____ Phone #_____

Address_____ City_____ Zip Code_____

Date you first saw any Doctor after accident _____

Is this Workman's Compensation? _____Is this Personal Injury?_____

Have you received any medical treatment since your accident? Y N

Hospital_____Cost_____

Medical Doctor _____Cost_____

Chiropractor_____Cost_____

Other_____Cost_____

_____

_____

_____

_____

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking the following medications _____

_____

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

Patient Signature _____ Dr. Signature _____