

SP ID# _____



Appointment Date: _____
Appointment Time: _____

****PLEASE USE BLACK INK****

*****PERSONAL INJURY*****

Patient Information

Please Print

Name _____ Date _____

Date of Birth _____ Social Security #: _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail Address _____

Occupation _____ Unemployed

Employer _____ Business Phone _____

Employer Address _____ Length of Employment _____

Second Employer _____ Phone: _____

Second Employer Address _____

Sex: Male Female Height _____ Weight _____ Dominant Hand: Left Right

Race: African American Asian Caucasian Hispanic Other

Are you: Married Single Domestic Partnership Divorced Separated Widowed

Spouse's Name: _____

Emergency Contact Name _____ Relationship _____

Contact Phone _____

Name of nearest relative not living with you: _____ Phone: _____

Private Health Insurance Information

Health Insurance Carrier _____ Waiver Signed

Health Insurance Address _____

Policy Number _____ Group Number _____

Policy Holder _____ DOB of Policy Holder _____

Employer of Policy Holder _____ Relationship _____

Patient's Signature: _____ Employee's Initials: _____

Accident Information

How were you injured? Auto W/C Slip & Fall Auto/While on Job

Cab Bus Motorcycle Pedestrian Other _____

Date of Injury _____ What State? _____

Brief description of how accident happened: _____

Did you strike your head or any other part of your body in this accident? _____

Have you been able to work since your accident? Yes No Last day worked? _____

Has an out of work slip been issued to you? Yes No

Auto Accident:

Were you the driver? Passenger? Seat Belted? Yes No

Has this accident been reported to the auto insurance company? Yes No

Driver's Name _____ Policy Holder's Name _____

Policy Holder's car insurance carrier _____

Policy Holder's Phone Number _____

PIP Adjuster: _____ **Phone #:** _____ **PIP Claim #:** _____

IF YOU DO NOT OWN A MOTOR VEHICLE:

Does anyone else in household own motor vehicles? Yes No

Workers Compensation:

Date of Injury _____ **WC Carrier** _____ **Claim#** _____

Who is/was your employer at the time of injury? _____

Employer Address _____
(City) (State) (Zip)

Employer Phone Number _____ Supervisor's Name _____

Have you filed a "First Report of Injury" with your employer? Yes No

Patient's Signature: _____ Employee's Initials: _____ 2

Prior Accidental Injuries

Please enter the information regarding **previous** accidents (**not including the current accident**), listing the most recent first.

WHAT TYPE OF ACCIDENT?

1st Accident

Auto Work Comp Auto/While on Job Cab Bus Motorcycle Pedestrian

Sports Military Duty Other: _____

When did the injury happen? _____ Where did the injury happen: _____

What was injured: _____ Where were you treated? _____

Date of last treatment? _____ Recovery: Full Partial

2nd Accident

Auto Work Comp Auto/While on Job Cab Bus Motorcycle Pedestrian

Sports Military Duty Other: _____

When did the injury happen? _____ Where did the injury happen: _____

What was injured: _____ Where were you treated? _____

Date of last treatment? _____ Recovery: Full Partial

3rd Accident

Auto Work Comp Auto/While on Job Cab Bus Motorcycle Pedestrian

Sports Military Duty Other: _____

When did the injury happen? _____ Where did the injury happen: _____

What was injured: _____ Where were you treated? _____

Date of last treatment? _____ Recovery: Full Partial

Patient's Signature: _____ Employee's Initials: _____ 3

Present Health

Why do you need an evaluation today? Check the appropriate area and briefly explain.
(Examples-pain, numbness, tingling, burning, weakness)

- Neck Shoulder Elbow Wrist Low Back Hip Knee Leg Ankle Foot
- Other (please specify): _____
- _____
- _____

When did the symptom(s) begin? _____

How did the pain symptom(s) start? Check the appropriate response or explain.

- Suddenly Gradually Twisting Pulling Fall Lifting Bending Hit by Object
- Sports No Apparent Cause _____

Did you go to the hospital, E.R., or Urgent Care? Yes Date(s)_____ No

Name of hospital, E.R. or Urgent Care: _____

Did you have X-rays, MRI, CT Scan, or other diagnostic testing? _____

Have you been treated anywhere else for this accident? Yes No

If yes, where?_____ Phone Number: _____

Have you been injured prior to this accident? Yes No

Have you ever had a Disability Rating for a previous accident? Yes No

Please list any medications you are currently taking _____

Please list any allergies (including drug and **latex allergies**) you may have:

Who is your Primary Care Provider? _____ Phone: _____

Primary Care Provider Address _____

Patient's Signature:_____ Employee's Initials:_____

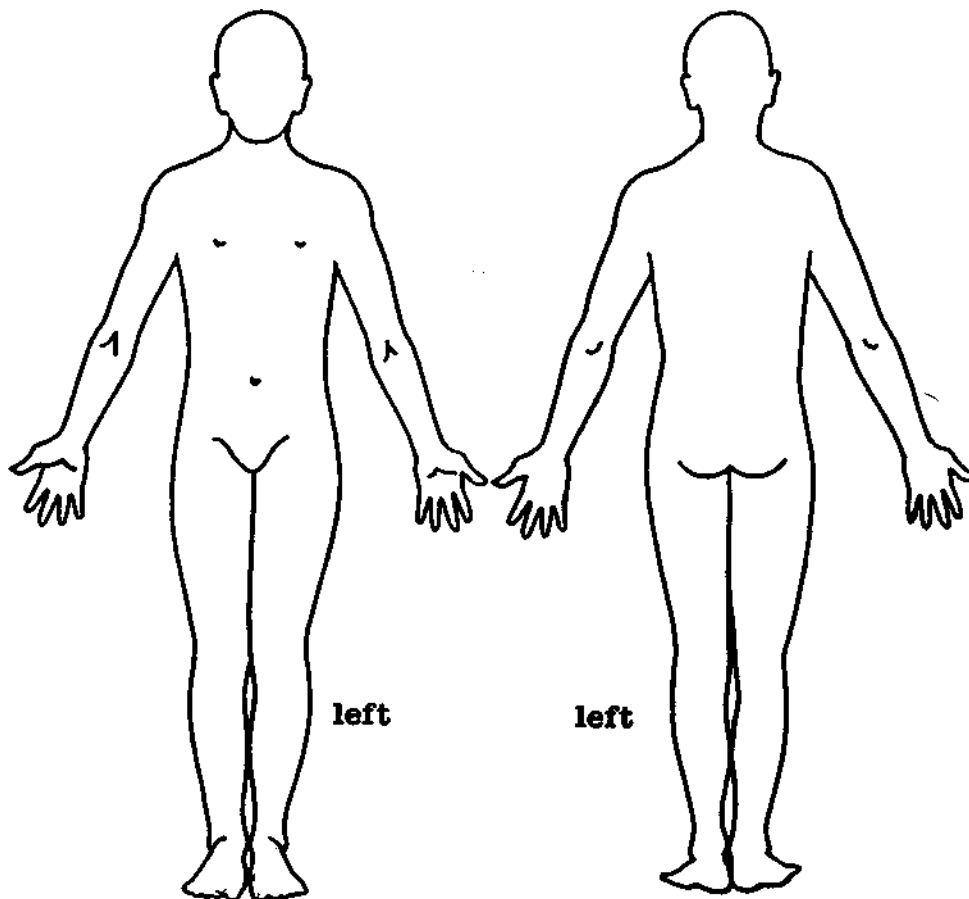
Pain Description

Please rate your pain on a scale of 1-10.
(1= mild pain, 10=the worse pain you've ever felt)

Areas of Injury	Pain Scale	Areas of Injury	Pain Scale	Areas of Injury	Pain Scale
Head		Left Shoulder		Right Shoulder	
Neck		Left Elbow		Right Elbow	
Upper Back		Left Wrist/Hand		Right Wrist/Hand	
Lower Back		Left Knee		Right Knee	
Hips		Left Ankle/Foot		Right Ankle/Foot	

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, stiffness, aching, or stabbing pain.

Numbness: □	Pins & Needles: .-.	Aching pain: ±
Stabbing pain: ↑	Burning: #	Stiffness: u



Review of Systems

Weight _____ Height _____

Medical History:Please mark any of the symptoms that **apply to you TODAY:**

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Abdominal Pain			Muscle Weakness		
Anxiety			Numbness or Tingling		
Chest Pain			Painful or Urgent Urination		
Cough			Rapid Hearth Beat		
Cuts that won't stop bleeding			Rash		
Depression			Shortness of Breath		
Fever/Chills			Swelling of Legs		
Frequent Urination			Vomiting		
Frequent/Easy Bruising			Discolored Stools		
Irregular Heart Beat			Wound Healing Problems		
Joint Pain or Swelling			Other: _____		
Muscle Pain or Swelling					

Check if you have had any of these conditions in the **PAST** or if there is any family history of these conditions:

MAJOR ILLNESS	YES	NO	FAMILY	MAJOR ILLNESS	YES	NO	FAMILY
Anemia				Liver Disease			
Arthritis				Kidney Disease			
Heart Arrhythmia/Palpations				Loss of Vision			
Asthma				Neuropathy			
Bleeding Problems				Paralysis			
Blood Clots				Peripheral Vascular Disease			
Cancer:				Pneumonia			
Chest Pain/Angina				Psychiatric Illness			
Diabetes				Pulmonary Embolism			
Gall Bladder Disease				Reflux			
Gastric Ulcers				Skin Ulcer/Breakdown			
Glaucoma				Steroid Use			
Heart Attack				Stroke			
Heart Failure				Thyroid Disease			
Heart Murmur				Tuberculosis-TB			
Hepatitis B				Urinary Infections			
Hepatitis C				Valve Disorders (Heart)			
High Blood Pressure				Wound Healing Problems			
HIV/AIDS				Orthopaedic Conditions:			
Immune Deficiency				Other: _____			

Patient's Signature: _____ Provider Initials: _____

Surgical History

Please list any surgeries and the dates they were performed:

Date:	Surgery:

Social History

Do you have Children?

Yes – How many: _____ No

Are you Pregnant? (**Women Only**)

Yes No

Do you Live Alone?

Yes No

Drugs/Alcohol:

History of Substance Abuse?

Yes No

Do you drink Alcoholic Beverages?

Yes – How much: _____ No

Do you smoke Cigarettes?

Yes - How much: _____ No

If you smoked in the past, how long has it been since you stopped?

0-3 months 3-6 months 6-12 months Over a year ago

Exercise:

Do you Exercise?

Daily Weekly Monthly Rarely Never

What type of Exercise?

Walking Running Swimming Weight Lifting Aerobics
 Other _____

Patient's Signature: _____ Provider Signature: _____