



PATIENT NAME: _____

TODAY'S DATE: ___/___/___

DATE OF LOSS: ___/___/___

PATIENT INTAKE: Premise Liability or Ped vs Auto**PATIENT PERSONAL INFORMATION**

| | | | | |
|---|-----------------------------|--|---|---|
| LAST NAME: | | FIRST NAME: | | MIDDLE INITIAL: |
| DATE OF BIRTH: | | AGE: | SOCIAL SECURITY NUMBER: | |
| ADDRESS: | | CITY: | STATE: | ZIP: |
| HOME PHONE: () | MOBILE PHONE: () | WORK PHONE: () | MAY WE LEAVE A VOICE MAIL AT THESE NUMBERS? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| E-MAIL ADDRESS: | | HEIGHT: | WEIGHT: | |
| MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | HAND DOMINANCE: <input type="checkbox"/> Right <input type="checkbox"/> Left | | GENDER: <input type="checkbox"/> M <input type="checkbox"/> F |

EMERGENCY CONTACT INFORMATION

| | |
|-------------------|---|
| FULL NAME: | RELATIONSHIP TO YOU: |
| PHONE: | MAY WE LEAVE A VOICE MAIL AT THIS NUMBER? <input type="checkbox"/> Yes <input type="checkbox"/> No |

INSURANCE INFORMATION

(Please list the following information on the vehicle you were in at the time of the collision.)

| | | |
|--|--|-----------------------------------|
| PERSON AT FAULT: <input type="checkbox"/> Self <input type="checkbox"/> Other Name/Company: | PERSON AT FAULT INSURANCE COMPANY (IF KNOWN): | |
| AT FAULT AUTO INSURANCE PHONE: () | AT FAULT POLICY NUMBER: | AT FAULT CLAIM NUMBER: |
| DO YOU HAVE PERSONAL MEDICAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No | | NAME OF MEDICAL INSURANCE: |

ATTORNEY INFORMATION

| | | | |
|---------------------------------|-------------------------------|--|-------------|
| FULL NAME: | NAME OF LAW FIRM: | | |
| ATTORNEY'S ADDRESS: | CITY: | STATE: | ZIP: |
| ATTORNEY'S PHONE: () | ATTORNEY'S FAX: () | PARALEGAL HANDLING CASE (IF KNOWN): | |

INITIALS: _____



PATIENT NAME: _____

TODAY'S DATE: ___/___/___

DATE OF LOSS: ___/___/___

INCIDENT INFORMATION FOR PREMISE LIABILITY

| | | |
|--|----------------------|--|
| DATE OF EVENT | TIME OF EVENT | LOCATION OF EVENT |
| DO YOU KNOW IF THERE IS A VIDEOTAPE OF THE INCIDENT? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HAS THE INSURANCE CARRIER CONTACTED YOU? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| DID ANYONE WITNESS THE FALL? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| DID THEY GIVE A WRITTEN STATEMENT? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| DO YOU HAVE A NAME AND NUMBER? | | <input type="checkbox"/> Yes <input type="checkbox"/> No If so please list them below |
| EXPLAIN BRIEFLEY HOW YOUR INCIDENT OCCURED: _____ _____ _____ | | |
| AT THE TIME OF THE INCIDENT, YOU WERE LOOKING: <input type="checkbox"/> Forward <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Backward | | |
| DO YOU THINK YOU LOST CONSCIOUSNESS? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, How Long? _____ <input type="checkbox"/> Sec. <input type="checkbox"/> Min. <input type="checkbox"/> Hours | | WERE YOU: <input type="checkbox"/> Shaken <input type="checkbox"/> Disoriented <input type="checkbox"/> Dazed If Yes, How Long? _____ <input type="checkbox"/> Sec. <input type="checkbox"/> Min. <input type="checkbox"/> Hours |
| DID YOU RECEIVE ANY: <input type="checkbox"/> Bruises <input type="checkbox"/> Cuts/Lacerations/Abrasions <u>IF SO PLEASE LIST THEM BELOW:</u> | | |

INCIDENT INFORMATION FOR PEDESTRIAN VS. AUTO

| | | | |
|--|---|--|--|
| DATE OF INCIDENT: | TIME OF INCIDENT: | WERE YOU A: | <input type="checkbox"/> Pedestrian <input type="checkbox"/> Cyclist |
| SPEED OF THE VEHICLE IMPACT: | MPH | WHERE WAS THE IMPACT TO YOUR BODY/BIKE? | <input type="checkbox"/> Front <input type="checkbox"/> Left Side <input type="checkbox"/> Back <input type="checkbox"/> Right Side |
| TYPE OF VEHICLE INVOLVED: | YEAR: | MAKE: | MODEL: |
| NAME OF THE STREET YOU WERE ON: | NAME OF THE STREET THE NEAREST CROSS STREET: | | |
| WERE YOU: <input type="checkbox"/> Walking <input type="checkbox"/> Crossing the Street <input type="checkbox"/> On the Sidewalk <input type="checkbox"/> Riding in the Street | | | |
| EXPLAIN BRIEFLEY HOW YOUR INCIDENT OCCURED: _____ _____ _____ | | | |
| DID YOU RECEIVE ANY: <input type="checkbox"/> Bruises <input type="checkbox"/> Cuts/Lacerations/Abrasions <u>IF SO PLEASE LIST THEM BELOW.</u> | | | |
| DID YOU HIT YOUR HEAD? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, WHERE? | | DO YOU THINK YOU LOST CONSCIOUSNESS? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, How Long? _____ <input type="checkbox"/> Sec. <input type="checkbox"/> Min. <input type="checkbox"/> Hrs | |
| WERE YOU: <input type="checkbox"/> Shaken <input type="checkbox"/> Disoriented <input type="checkbox"/> Dazed If Yes, How Long? _____ <input type="checkbox"/> Sec. <input type="checkbox"/> Min. <input type="checkbox"/> Hours | | DID THE POLICE COME TO THE SCENE? <input type="checkbox"/> Yes <input type="checkbox"/> No DEPARTMENT: | DO YOU HAVE A POLICE REPORT/ CASE NUMBER? C# |

INITIALS: _____



PATIENT NAME: _____

TODAY'S DATE: ___/___/___

DATE OF LOSS: ___/___/___

WERE YOU TREATED ON THE SCENE BY PARAMEDICS?

Yes No

DID YOU GO TO THE EMERGENCY ROOM, HOSPITAL, OR URGENT CARE?

Yes No (Please indicate below which hospital)

IF "YES", WHEN DID YOU GO?

Day of the collision Other Date: ___/___/___

IF THE DAY OF THE COLLISION, HOW DID YOU GET THERE?

Ambulance Self Other: _____

| Hospital/Provider | Date | Hospital/ Provider | Date | Hospital/ Provider | Date |
|--|-------------|---|-------------|---|-------------|
| <input type="checkbox"/> Children's Hospital | ___/___/___ | <input type="checkbox"/> Medical Center of Aurora | ___/___/___ | <input type="checkbox"/> St. Anthony's Central | ___/___/___ |
| <input type="checkbox"/> Denver Health | ___/___/___ | <input type="checkbox"/> North Suburban Medical | ___/___/___ | <input type="checkbox"/> St. Joseph's Hospital | ___/___/___ |
| <input type="checkbox"/> Good Samaritan | ___/___/___ | <input type="checkbox"/> Porter Adventist | ___/___/___ | <input type="checkbox"/> Swedish Medical Center | ___/___/___ |
| <input type="checkbox"/> Kaiser Permanente | ___/___/___ | <input type="checkbox"/> Rose Medical Center | ___/___/___ | <input type="checkbox"/> University Hospital | ___/___/___ |
| <input type="checkbox"/> Littleton Adventist | ___/___/___ | <input type="checkbox"/> St. Anthony North | ___/___/___ | <input type="checkbox"/> Sky Ridge Medical | ___/___/___ |
| <input type="checkbox"/> Lutheran Med. Cent | ___/___/___ | | | | |

WHERE HAVE YOU GONE FOR ADDITIONAL TREATMENT SINCE THE COLLISION? (CHECK ALL THAT APPLY)

| | | | | | |
|-----------------------------|-------|--------------------|-------|--------------------------|-------|
| Primary Care Doctor: | _____ | Start Date | _____ | Number of visits: | _____ |
| Physical Therapy: | _____ | Start Date: | _____ | Number of Visits: | _____ |
| Chiropractic: | _____ | Start Date: | _____ | Number of Visits: | _____ |
| Specialist: | _____ | Start Date: | _____ | Number of Visits: | _____ |
| Surgery: | _____ | Date: | _____ | Location: | _____ |

WHICH OF THE FOLLOWING DIAGNOSTIC TESTS HAVE YOU HAD FOR THIS COLLISION?

| | FACILITY | BODY PART | DATE | KNOWN RESULTS |
|-------------------------------------|----------|-----------|-------------|---------------|
| <input type="checkbox"/> X-RAY | _____ | _____ | ___/___/___ | _____ |
| <input type="checkbox"/> CT Scan | _____ | _____ | ___/___/___ | _____ |
| <input type="checkbox"/> MRI | _____ | _____ | ___/___/___ | _____ |
| <input type="checkbox"/> Ultrasound | _____ | _____ | ___/___/___ | _____ |

DID YOU HAVE A GAP/BREAK IN CARE FOR THIS COLLISION (I.E. DID NOT SEE A HEALTH CARE PROVIDER WITHIN THE FIRST FEW DAYS OR HAD A BREAK IN CARE AGAIN FOR 2 WEEKS OR MORE)?

Yes No

IF "YES" TO ANY OF THE ABOVE, PLEASE CHECK THE REASON(S) FROM THE FOLLOWING LIST:

- I thought I would get better with time or assumed I could treat myself at home.
- I could not afford to pay out-of-pocket expenses for needed care.
- I was out of town and unable to find a provider in that area.
- I was afraid I would lose my job.
- Had to make and wait for the appointment.
- Other: _____
- I have no health insurance.
- I ran out of health insurance benefits.
- I was refused treatment at the doctor's office as it was auto insurance.
- Insurance Company problems over treatment and/or payment.
- Unsure on what to do or where to go for help.

INITIALS: _____



PATIENT NAME: _____

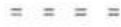
TODAY'S DATE: ___/___/___

DATE OF LOSS: ___/___/___

Please mark all areas of pain with the symbols below.



ACHING



NUMBNESS



PINS & NEEDLES



BURNING



STABBING

Right

Left

Left

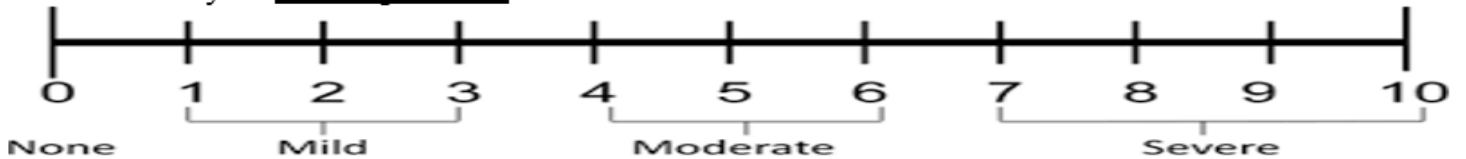
Right



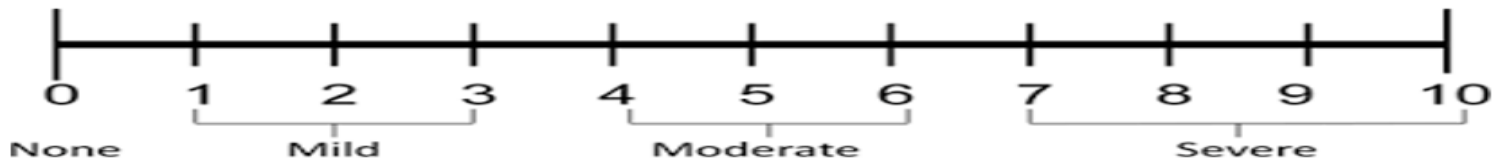
DO YOU HAVE ANY OF THE FOLLOWING:

- Loss of Bowel/Bladder Function
- Dizziness/Light Headed
- Vision Changes (Blurred/Double)
- Headache (Draw on person)
- None

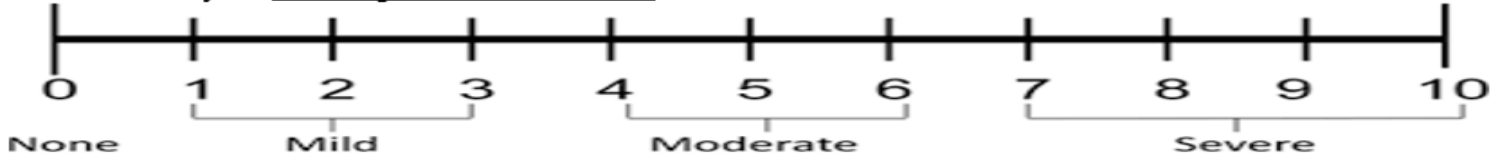
How bad is your **overall pain now**? Mark on this line below.



How bad is your **overall pain at its worst**? Mark on this line below.



How bad is your **overall pain at its best/least**? Mark on this line below.



INITIALS: _____



PATIENT NAME: _____

TODAY'S DATE: ___/___/___

DATE OF LOSS: ___/___/___

CURRENT COMPLAINTS

What are your main problems or difficulties NOW? (Check all that apply)

1. For each area of complaint, please provide a pain rating from the following scale:

| | | | | | |
|------|---------|------|----------|--------|---------------|
| None | Minimal | Mild | Moderate | Severe | Most Possible |
|------|---------|------|----------|--------|---------------|

2. For each area of complaint, please describe the type of pain using the following descriptors:

- | | | |
|----------|-----------|----------------|
| Achy | Sharp | Shooting |
| Dull | Burning | Pins & Needles |
| Stabbing | Throbbing | Tightness |

| Complaints NOW | Pain Rating (From Above) | Type of Pain | Did You Have This Complaint BEFORE the Collision? |
|--|-----------------------------|--------------|--|
| <input type="checkbox"/> Headaches | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Facial Pain | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Neck Pain | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Upper Back Pain | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Mid-Back Pain | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Lower Back Pain | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Buttock Pain | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Hip Pain (Left) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Hip Pain (Right) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Knee Pain (Left) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Knee Pain (Right) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Ankle Pain (Left) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Ankle Pain (Right) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Shoulder Pain (Left) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Shoulder Pain (Right) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Chest/Rib Pain | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Elbow Pain (Left) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Elbow Pain (Right) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Wrist / Hand Pain (Left) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Wrist / Hand Pain (Right) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Bowel / Bladder Dysfunction | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Dizziness / Light Headed | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Loss of Balance | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Ringing / Buzzing in the Ears | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Vision Changes (Blurred/Double) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Loss of Smell or Taste | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other: | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other: | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other: | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

INITIALS: _____



PATIENT NAME: _____

TODAY'S DATE: ___/___/___

DATE OF LOSS: ___/___/___

EMOTIONAL/BEHAVIORAL CHANGES

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- | | | |
|--|---|--|
| <input type="checkbox"/> Depression / Sadness | <input type="checkbox"/> Nervous/ Worried | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Nightmares About Accident | <input type="checkbox"/> Problems Thinking | <input type="checkbox"/> Sensitive to Sound/Light/Motion |
| <input type="checkbox"/> Irritable/Angry | <input type="checkbox"/> Appetite Changes (Loss / Gain) | <input type="checkbox"/> Feeling Tired All The Time |
| <input type="checkbox"/> Discouraged / Frustrated | <input type="checkbox"/> Driving Anxiety | <input type="checkbox"/> Other: _____ |

COGNITIVE CHANGES

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- | | | |
|---|---|---|
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Difficulty Problem Solving | <input type="checkbox"/> Getting Lost or Confused |
| <input type="checkbox"/> Lack of Concentration | <input type="checkbox"/> Slow in Thinking/Acting/Speaking | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Difficulty Understanding words or instructions | <input type="checkbox"/> Trouble Finding Words | _____ |

At any time during the event, did you think you might die or not survive?

I stay away from the things that remind me of the event?

Sometimes images from the event pop into my mind even when I am not thinking about it?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |

WHAT INCREASES YOUR PAIN? (CHECK ALL THAT APPLY)

- | | | |
|--|---|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lifting | <input type="checkbox"/> Lying Down |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Grasping |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Work | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Stress or Tension | <input type="checkbox"/> Coughing or Sneezing | <input type="checkbox"/> Weather Changes |
| <input type="checkbox"/> Other: _____ | | |

WHAT DECREASES YOUR PAIN? (CHECK ALL THAT APPLY)

- | | | |
|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Rest | <input type="checkbox"/> Medications | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Stretching | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Lying Down |
| <input type="checkbox"/> Other: _____ | | |

ACTIVITIES OF DAILY LIVING / FUNCTIONAL STATUS

(These questions are about how your symptoms/injuries affect your activities now. Check ALL the activities that have been limited in the last 4 weeks due to your injuries/collision.)

BASIC SELF-CARE / ACTIVITIES OF DAILY LIVING:

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Bathing / Showering | <input type="checkbox"/> Dressing | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Brushing Teeth | <input type="checkbox"/> Combing Hair | <input type="checkbox"/> Sexual Activity |

COMPLEX SELF-CARE AND HOUSEHOLD DUTIES:

- | | | |
|---|---|---|
| <input type="checkbox"/> Meal Preparation | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Yard Work |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Sweeping / Mopping | <input type="checkbox"/> Managing Medications |
| <input type="checkbox"/> Financial Management | <input type="checkbox"/> Other: _____ | |

BASIC MOBILITY:

- | | | |
|---|---|---|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Bending | <input type="checkbox"/> Driving/Riding |
| <input type="checkbox"/> Running | <input type="checkbox"/> Sit-to-Stand | <input type="checkbox"/> Kneeling |
| <input type="checkbox"/> Grasping | <input type="checkbox"/> Lifting Above Shoulder | <input type="checkbox"/> Lifting from Floor |
| <input type="checkbox"/> Squatting / Stooping | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Pushing | <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Moving Neck |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Getting Up from lying down | <input type="checkbox"/> Other: _____ |

BASIC COMMUNICATION:

- | | | |
|----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Speaking | <input type="checkbox"/> Computer Use |
| <input type="checkbox"/> Writing | <input type="checkbox"/> Typing | <input type="checkbox"/> Texting |

CHILDCARE ACTIVITIES: (N/A, I Do Not Have Small Children)

- | | | |
|---|---|--|
| <input type="checkbox"/> Lifting/Holding | <input type="checkbox"/> Dressing Child | <input type="checkbox"/> Helping w/Homework |
| <input type="checkbox"/> Changing Diapers | <input type="checkbox"/> Bathing Child | <input type="checkbox"/> Car Seat Management |

Other: _____

Number of Children: _____

Age(s) of Children: _____

INITIALS: _____



PATIENT NAME: _____

TODAY'S DATE: ___/___/___

DATE OF LOSS: ___/___/___

SLEEPING BEHAVIOR:

DO YOU HAVE PROBLEMS SLEEPING DUE TO YOUR PAIN?
HOW MANY HOURS OF RESTFUL SLEEP DO YOU GET PER NIGHT?

Yes No

DO YOU SLEEP TOO MUCH?

Yes No

HOW MANY TIMES PER NIGHT DO YOU WAKE UP WITH PAIN?

ARE THERE ANY HOBBIES OR RECREATIONAL ACTIVITIES YOU COULD DO PREVIOUSLY THAT YOU CANNOT DO NOW?

Yes No If "Yes", what activities: _____

CHECK ALL CURRENT AND/OR PAST MEDICAL CONDITIONS (Not related to this collision):

| | CURRENT | PAST | | CURRENT | PAST |
|----------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| HIGH BLOOD PRESSURE | <input type="checkbox"/> | <input type="checkbox"/> | BLOOD/ANEMIA/BRUISING | <input type="checkbox"/> | <input type="checkbox"/> |
| HEAD/ HEADACHES | <input type="checkbox"/> | <input type="checkbox"/> | BONES/ JOINTS | <input type="checkbox"/> | <input type="checkbox"/> |
| HEART DISEASE/ CIRCULATION | <input type="checkbox"/> | <input type="checkbox"/> | EYES/VISION | <input type="checkbox"/> | <input type="checkbox"/> |
| DEPRESSION/ANXIETY/BIPOLAR | <input type="checkbox"/> | <input type="checkbox"/> | DIABETES | <input type="checkbox"/> | <input type="checkbox"/> |
| COPD/LUNGS/ASTHMA | <input type="checkbox"/> | <input type="checkbox"/> | KIDNEY DISEASE | <input type="checkbox"/> | <input type="checkbox"/> |
| THYROID DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | OSTEOPOROSIS | <input type="checkbox"/> | <input type="checkbox"/> |
| SLEEP APNEA/SLEEPING | <input type="checkbox"/> | <input type="checkbox"/> | PREGNANCY | <input type="checkbox"/> | <input type="checkbox"/> |
| HIGH CHOLESTEROL | <input type="checkbox"/> | <input type="checkbox"/> | CANCER | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS/HIV POSITIVE | <input type="checkbox"/> | <input type="checkbox"/> | STOMACH/BOWELS | <input type="checkbox"/> | <input type="checkbox"/> |
| LIVER DISEASE | <input type="checkbox"/> | <input type="checkbox"/> | FEMALE PARTS | <input type="checkbox"/> | <input type="checkbox"/> |
| SEIZURES/EPILEPSY | <input type="checkbox"/> | <input type="checkbox"/> | MALE PARTS | <input type="checkbox"/> | <input type="checkbox"/> |
| EARS/HEARING | <input type="checkbox"/> | <input type="checkbox"/> | BRAIN | <input type="checkbox"/> | <input type="checkbox"/> |
| OTHER: _____ | | | | <input type="checkbox"/> | <input type="checkbox"/> |

HAVE YOU EVER HAD ANY SURGERIES/HOSPITALIZATIONS? Yes No If "Yes", please list:

| TYPE OF SURGERY / WHY HOSPITALIZED | YEAR | FULLY RECOVERED? |
|------------------------------------|------|--|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

EVER BEEN IN AN AUTO COLLISION BEFORE?

Yes No

IF "YES", HOW MANY? _____

WHEN? _____

DID YOU COMPLETELY RECOVER?

Yes No

IF YOU DID NOT COMPLETELY RECOVER, WHAT ARE THE RESIDUAL COMPLAINTS? (N/A)

EVER HAD A WORK-RELATED INJURY?

Yes No

IF "YES", HOW MANY? _____

WHEN? _____

DID YOU COMPLETELY RECOVER?

Yes No

IF YOU DID NOT COMPLETELY RECOVER, WHAT ARE THE RESIDUAL COMPLAINTS? (N/A)

ARE YOU ALLERGIC TO ANY MEDICATIONS?

Yes No If "Yes", Explain: ____

ARE YOU ALLERGIC TO LATEX?

Yes No

ARE YOU ALLERGIC TO MEDICAL TAPES?

Yes No

INITIALS: _____



PATIENT NAME: _____

TODAY'S DATE: ___/___/___

DATE OF LOSS: ___/___/___

DO YOU USE THE FOLLOWING? Cane Walker Crutches Wheelchair **IF SO, HOW LONG?** _____

MEDICATIONS

Please list **ALL PRESCRIPTION** medications that you are **CURRENTLY** taking:

| MEDICATION | DOSE | HOW OFTEN? | WHEN STARTED? | WHY? |
|------------|------|------------|---------------|------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please list **ALL OVER-THE-COUNTER** medications that you are **CURRENTLY** taking:

| MEDICATION | DOSE | HOW OFTEN? | WHEN STARTED? | WHY? |
|------------|------|------------|---------------|------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

FAMILY MEDICAL HISTORY (Examples: Diabetes, High Blood Pressure, Cancer, etc.)

Mother: _____

Father: _____

Siblings/ Other Relatives: _____

OCCUPATION / WORK HISTORY

(The purpose of this section is to understand how your injuries have affected your work.)

| | |
|---|--------------------------------|
| CURRENT EMPLOYER: | JOB TITLE / OCCUPATION: |
| JOB DUTIES AND RESPONSIBILITIES: | |

WHAT ARE THE PHYSICAL REQUIREMENTS OF YOUR JOB? (CHECK ALL THAT APPLY)

- Sitting Standing Typing Bending
- Squatting Kneeling Climbing (Ladders, etc.) Lifting (_____ lbs.)

HAVE YOU MISSED ANY TIME FROM WORK DUE TO THIS COLLISION? Yes No I have not returned to work **IF YES, HOW MANY HOURS OR DAYS HAVE YOU MISSED?** _____

IF YOU ARE CURRENTLY WORKING, ARE YOU MODIFYING YOUR HOURS OR DUTIES? (CHECK ALL THAT APPLY):
 Normal Hours Decreased Hours Normal Job Duties Modified Job Duties Different Jobs

If you are working a different job since the collision, please explain: _____

SOCIAL HISTORY

DO YOU SMOKE/USE TOBACCO? Yes No **IF "YES", HOW OFTEN?** _____ / Day Week Month

DO YOU DRINK ALCOHOL? Yes No **IF "YES", HOW OFTEN?** _____ / Day Week Month

INITIALS: _____



SYNERGY

HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/___

DATE OF LOSS: ___/___/___

DO YOU USE ILLEGAL DRUGS?

Yes No

WHAT IS THE HIGHEST EDUCATION LEVEL YOU HAVE COMPLETED?

Elementary High School Vocational Some College College Degree Advanced Degree Other: _____

PATIENT AFFIRMATION: *By signing below, you confirm that the information you provided is accurate to the best of your knowledge.*

Patient's Signature: _____ Date: ___/___/___

Parent / Guardian Signature (If patient is a minor): _____ Date: ___/___/___

Photo Permission: *I give my permission to take my photo for the purposes of chart identification and, if necessary, to document portions of the physical exam.*

Patient's Signature: _____ Date: ___/___/___

If filled out by a person other than the patient, please provide name and signature below.

Printed Name: _____ Signature: _____

INITIALS: _____