SYNERGY HEALTH PARTNERS

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?** ☐ Yes ☐ No
E-MAIL ADDRESS:	**HEIGHT:**	**WEIGHT:**	
MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed	**HAND DOMINANCE:** ☐ Right ☐ Left	**GENDER:** ☐ M ☐ F	

EMERGENCY CONTACT INFORMATION

FULL NAME:	**RELATIONSHIP TO YOU:**
PHONE:	**MAY WE LEAVE A VOICE MAIL AT THIS NUMBER?** ☐ Yes ☐ No

INSURANCE INFORMATION

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

PERSON AT FAULT: ☐ Self ☐ 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? ☐ Yes ☐ 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:_____

SYNERGY HEALTH PARTNERS

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? ☐ **Yes** ☐ **No**

HAS THE INSURANCE CARRIER CONTACTED YOU? ☐ **Yes** ☐ **No**

DID ANYONE WITNESS THE FALL? ☐ **Yes** ☐ **No**

DID THEY GIVE A WRITTEN STATEMENT? ☐ **Yes** ☐ **No**

DO YOU HAVE A NAME AND NUMBER? ☐ **Yes** ☐ **No** **If so please list them below**

EXPLAIN BRIEFLEY HOW YOUR INCIDENT OCCURED: _____

_____

_____

_____

AT THE TIME OF THE INCIDENT, YOU WERE LOOKING: ☐ Forward ☐ Right ☐ Left ☐ Backward

DO YOU THINK YOU LOST CONSCIOUSNESS? ☐ Yes ☐ No If Yes, How Long? _____ ☐ Sec. ☐ Min. ☐ Hours

WERE YOU: ☐ Shaken ☐ Disoriented ☐ Dazed If Yes, How Long? _____ ☐ Sec. ☐ Min. ☐ Hours

DID YOU RECEIVE ANY: ☐ Bruises ☐ Cuts/Lacerations/Abrasions **IF SO PLEASE LIST THEM BELOW**:

INCIDENT INFORMATION FOR PEDESTRIAN VS. AUTO

DATE OF INCIDENT:		**TIME OF INCIDENT:**		**WERE YOU A:**	☐ Pedestrian ☐ Cyclist
SPEED OF THE VEHICLE IMPACT:	**MPH**	**WHERE WAS THE IMPACT TO YOUR BODY/BIKE?**		☐ Front ☐ Left Side ☐ Back ☐ 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: ☐ Walking ☐ Crossing the Street ☐ On the Sidewalk ☐ Riding in the Street

EXPLAIN BRIEFLEY HOW YOUR INCIDENT OCCURED: _____

_____

_____

_____

_____

DID YOU RECEIVE ANY: ☐ Bruises ☐ Cuts/Lacerations/Abrasions **IF SO PLEASE LIST THEM BELOW**.

DID YOU HIT YOUR HEAD? ☐ **Yes** ☐ **No** **IF YES, WHERE?**	**DO YOU THINK YOU LOST CONSCIOUSNESS?** ☐ Yes ☐ No If Yes, How Long? _____ ☐ Sec. ☐ Min. ☐ Hrs	
WERE YOU: ☐ Shaken ☐ Disoriented ☐ Dazed If Yes, How Long? _____ ☐ Sec. ☐ Min. ☐ Hours	**DID THE POLICE COME TO THE SCENE?** ☐ **Yes** ☐ **No** **DEPARTMENT:**	**DO YOU HAVE A POLICE REPORT/ CASE NUMBER? C#**

INITIALS:_____

SYNERGY HEALTH PARTNERS

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
☐ Children's Hospital	__/__/__	☐ Medical Center of Aurora	__/__/__	☐ St. Anthony's Central	__/__/__
☐ Denver Health	__/__/__	☐ North Suburban Medical	__/__/__	☐ St. Joseph's Hospital	__/__/__
☐ Good Samaritan	__/__/__	☐ Porter Adventist	__/__/__	☐ Swedish Medical Center	__/__/__
☐ Kaiser Permanente	__/__/__	☐ Rose Medical Center	__/__/__	☐ University Hospital	__/__/__
☐ Littleton Adventist	__/__/__	☐ St. Anthony North	__/__/__	☐ Sky Ridge Medical	__/__/__
☐ 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 <u>THIS COLLISION</u>?

	FACILITY	BODY PART	DATE	KNOWN RESULTS
☐ X-RAY	_____	_____	___/___/___	_____
☐ CT Scan	_____	_____	___/___/___	_____
☐ MRI	_____	_____	___/___/___	_____
☐ Ultrasound	_____	_____	___/___/___	_____

DID YOU HAVE A GAP/BREAK IN CARE FOR <u>THIS COLLISION</u> (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.
- ☐ 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.
- ☐ Other:_____

INITIALS:_____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/____

DATE OF LOSS: ___/___/____

Please mark all areas of pain with the symbols below.

▽ ▽ ▽ ▽ ACHING

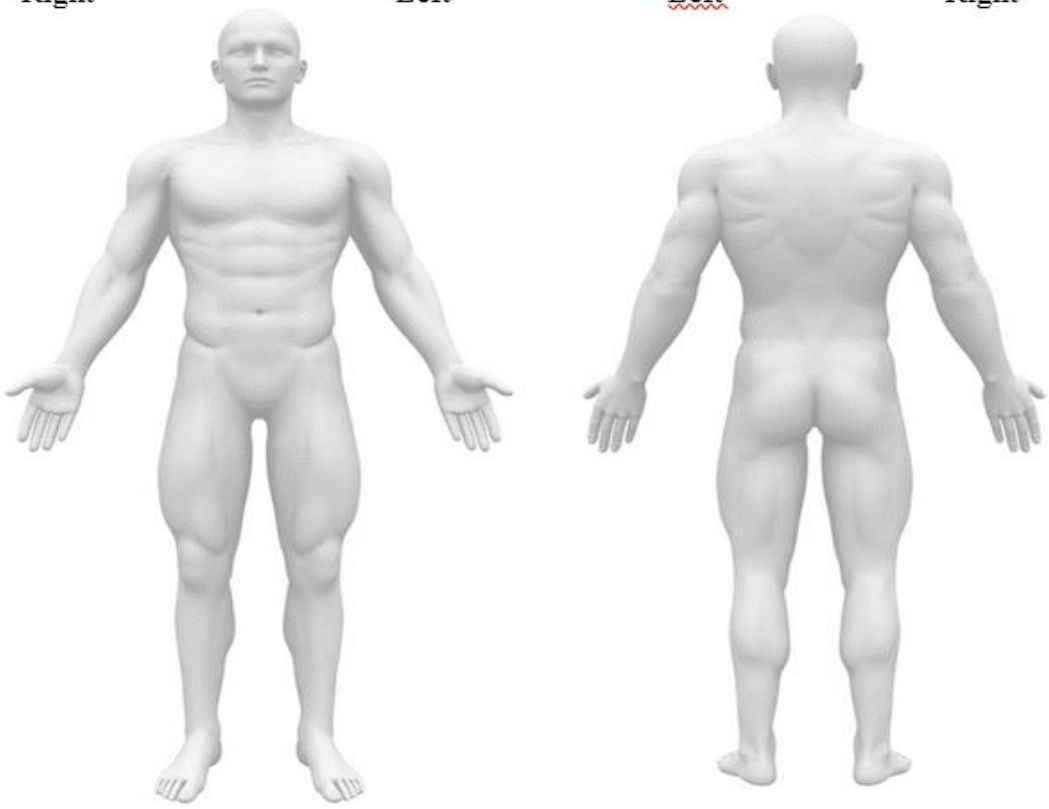
= = = = NUMBNESS

• • • • PINS & NEEDLES

X X X X BURNING

//// STABBING

Right Left Left Right



DO YOU HAVE ANY OF THE FOLLOWING:

☐ Loss of Bowel/ Bladder Function

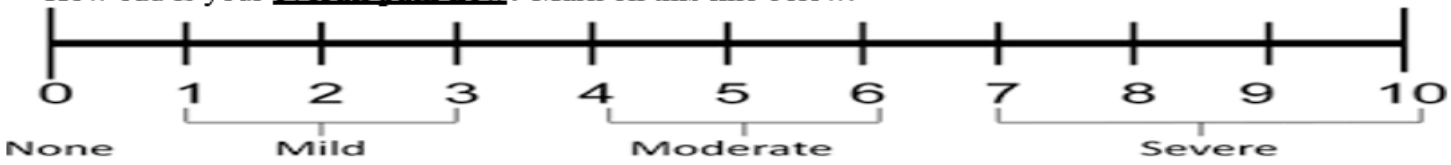
☐ Dizziness/Light Headed

☐ Vision Changes (Blurred/Double)

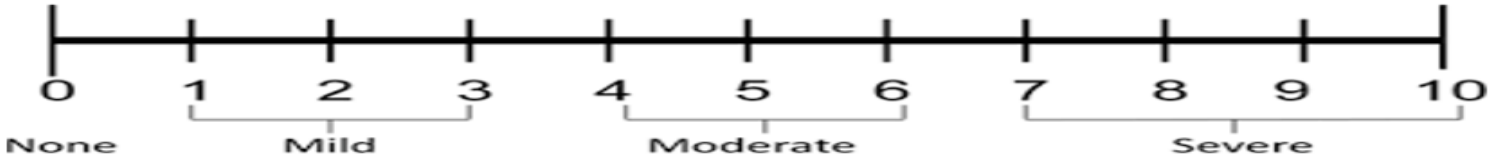
☐ Headache (Draw on person)

☐ None

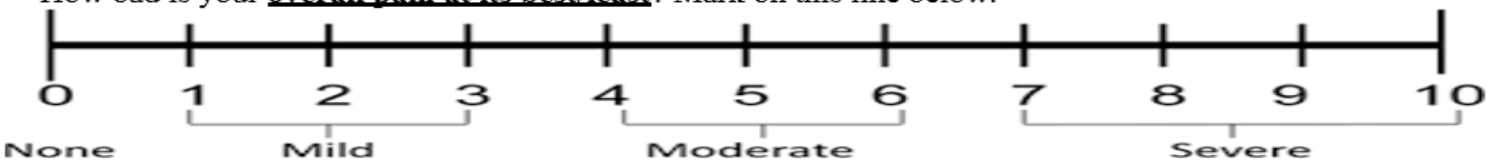
How bad is your **overall pain now**? Mark on this line below.



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:_____

SYNERGY HEALTH PARTNERS

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?
☐ **Headaches**			☐ Yes ☐ No
☐ **Facial Pain**			☐ Yes ☐ No
☐ **Neck Pain**			☐ Yes ☐ No
☐ **Upper Back Pain**			☐ Yes ☐ No
☐ **Mid-Back Pain**			☐ Yes ☐ No
☐ **Lower Back Pain**			☐ Yes ☐ No
☐ **Buttock Pain**			☐ Yes ☐ No
☐ **Hip Pain (Left)**			☐ Yes ☐ No
☐ **Hip Pain (Right)**			☐ Yes ☐ No
☐ **Knee Pain (Left)**			☐ Yes ☐ No
☐ **Knee Pain (Right)**			☐ Yes ☐ No
☐ **Ankle Pain (Left)**			☐ Yes ☐ No
☐ **Ankle Pain (Right)**			☐ Yes ☐ No
☐ **Shoulder Pain (Left)**			☐ Yes ☐ No
☐ **Shoulder Pain (Right)**			☐ Yes ☐ No
☐ **Chest/Rib Pain**			☐ Yes ☐ No
☐ **Elbow Pain (Left)**			☐ Yes ☐ No
☐ **Elbow Pain (Right)**			☐ Yes ☐ No
☐ **Wrist / Hand Pain (Left)**			☐ Yes ☐ No
☐ **Wrist / Hand Pain (Right)**			☐ Yes ☐ No
☐ **Bowel / Bladder Dysfunction**			☐ Yes ☐ No
☐ **Dizziness / Light Headed**			☐ Yes ☐ No
☐ **Loss of Balance**			☐ Yes ☐ No
☐ **Ringing / Buzzing in the Ears**			☐ Yes ☐ No
☐ **Vision Changes** (Blurred/Double)			☐ Yes ☐ No
☐ **Loss of Smell or Taste**			☐ Yes ☐ No
☐ **Other:**			☐ Yes ☐ No
☐ **Other:**			☐ Yes ☐ No
☐ **Other:**			☐ Yes ☐ No

INITIALS:_____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/____

DATE OF LOSS: ___/___/____

EMOTIONAL/BEHAVIORAL CHANGES

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

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

COGNITIVE CHANGES

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

- ☐ Forgetful
- ☐ Lack of Concentration
- ☐ Difficulty Understanding words or instructions
- ☐ Difficulty Problem Solving
- ☐ Slow in Thinking/Acting/Speaking
- ☐ Trouble Finding Words
- ☐ Getting Lost or Confused
- ☐ Other:_____

At any time during the event, did you think you might die or not survive? ☐ Yes ☐ No

I stay away from the things that remind me of the event? ☐ Yes ☐ No

Sometimes images from the event pop into my mind even when I am not thinking about it? ☐ Yes ☐ No

WHAT INCREASES YOUR PAIN? (CHECK ALL THAT APPLY)

- ☐ Sitting
- ☐ Standing
- ☐ Bending
- ☐ Stress or Tension
- ☐ Lifting
- ☐ Walking
- ☐ Work
- ☐ Coughing or Sneezing
- ☐ Lying Down
- ☐ Grasping
- ☐ Reaching
- ☐ Weather Changes
- ☐ Other:_____

WHAT DECREASES YOUR PAIN? (CHECK ALL THAT APPLY)

- ☐ Rest
- ☐ Ice
- ☐ Physical Therapy
- ☐ Sitting
- ☐ Medications
- ☐ Stretching
- ☐ Chiropractic
- ☐ Standing
- ☐ Heat
- ☐ Exercise
- ☐ Massage
- ☐ Lying Down
- ☐ 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:

- ☐ Bathing / Showering
- ☐ Brushing Teeth
- ☐ Dressing
- ☐ Combing Hair
- ☐ Eating
- ☐ Sexual Activity

COMPLEX SELF-CARE AND HOUSEHOLD DUTIES:

- ☐ Meal Preparation
- ☐ Cleaning
- ☐ Financial Management
- ☐ Vacuuming
- ☐ Sweeping / Mopping
- ☐ Other: _____
- ☐ Yard Work
- ☐ Managing Medications

BASIC MOBILITY:

- ☐ Walking
- ☐ Running
- ☐ Grasping
- ☐ Squatting / Stooping
- ☐ Pushing
- ☐ Reaching
- ☐ Bending
- ☐ Sit-to-Stand
- ☐ Lifting Above Shoulder
- ☐ Lying Down
- ☐ Climbing Stairs
- ☐ Getting Up from lying down
- ☐ Driving/Riding
- ☐ Kneeling
- ☐ Lifting from Floor
- ☐ Pulling
- ☐ Moving Neck
- ☐ Other:_____

BASIC COMMUNICATION:

- ☐ Hearing
- ☐ Writing
- ☐ Speaking
- ☐ Typing
- ☐ Computer Use
- ☐ Texting

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

- ☐ Lifting/Holding
- ☐ Changing Diapers
- ☐ Other: _____
- ☐ Dressing Child
- ☐ Bathing Child

Number of Children: _____

- ☐ Helping w/Homework
- ☐ Car Seat Management

Age(s) of Children: _____

INITIALS:_____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: ___/___/____

DATE OF LOSS: ___/___/____

SLEEPING BEHAVIOR:

DO YOU HAVE PROBLEMS SLEEPING DUE TO YOUR PAIN? ☐ Yes ☐ No

HOW MANY HOURS OF RESTFUL SLEEP DO YOU GET PER NIGHT? _____

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	☐	☐	BLOOD/ANEMIA/BRUISING	☐	☐
HEAD/ HEADACHES	☐	☐	BONES/ JOINTS	☐	☐
HEART DISEASE/ CIRCULATION	☐	☐	EYES/VISION	☐	☐
DEPRESSION/ANXIETY/BIPOLAR	☐	☐	DIABETES	☐	☐
COPD/LUNGS/ASTHMA	☐	☐	KIDNEY DISEASE	☐	☐
THYROID DISEASE	☐	☐	OSTEOPOROSIS	☐	☐
SLEEP APNEA/SLEEPING	☐	☐	PREGNANCY	☐	☐
HIGH CHOLESTEROL	☐	☐	CANCER	☐	☐
AIDS/HIV POSITIVE	☐	☐	STOMACH/BOWELS	☐	☐
LIVER DISEASE	☐	☐	FEMALE PARTS	☐	☐
SEIZURES/EPILEPSY	☐	☐	MALE PARTS	☐	☐
EARS/HEARING	☐	☐	BRAIN	☐	☐
OTHER:_____				☐	☐

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

TYPE OF SURGERY / WHY HOSPITALIZED	YEAR	FULLY RECOVERED?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ 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:_____

SYNERGY HEALTH PARTNERS

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 Releatives: _____

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:_____