

Welcome

Patient Information

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship _____ Date _____

Phone Numbers

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext _____

Accident Information

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching

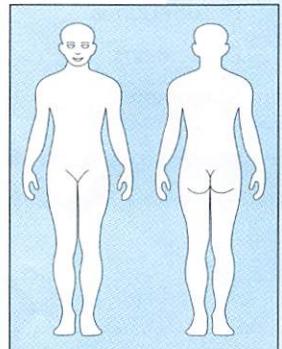
Shooting Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy
 Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Emphysema	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Miscarriage	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Scarlet Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Alcoholism	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Epilepsy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Mononucleosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Allergy Shots	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Fractures	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Multiple Sclerosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Suicide Attempt	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Anemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Glaucoma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Mumps	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Thyroid Problems	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Anorexia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Goiter	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Osteoporosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tonsillitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Appendicitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Gonorrhea	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pacemaker	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tuberculosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Arthritis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Gout	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Parkinson's Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Tumors, Growths	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pinched Nerve	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Typhoid Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bleeding Disorders	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hepatitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Pneumonia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Ulcers	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Breast Lump	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Hernia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Polio	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vaginal Infections	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bronchitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Herniated Disk	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Prostate Problem	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Venereal Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Bulimia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Herpes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Prosthesis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Whooping Cough	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	High Cholesterol	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Psychiatric Care	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other _____				
Cataracts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Kidney Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Rheumatoid Arthritis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____				
Chemical Dependency	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Liver Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Rheumatic Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____				
Chicken Pox	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Measles	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____									
Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Migraine Headaches	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	_____									

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name _____ Pharmacy Phone _____		
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OIWC PERSONAL INJURY QUESTIONNAIRE

Name _____ Home Phone _____ Work _____ Cell _____
Address _____ City _____ State _____ Zip _____
Age _____ Date of Birth _____ Marital Status _____ Sex _____
Email address _____
Employer's Name _____ Employer's Address _____

EMERGENCY CONTACT

Name _____ Relationship _____ Home _____ Cell _____

AUTO INSURANCE

Your Auto Ins. Co. _____ Policy # _____ Adjuster's Name _____
Name on Policy (if other than self) _____ Claim# _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Ins. Co. Phone # _____ Ext _____

ATTORNEY

Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Attorney email address _____

Were there any witnesses? No Yes Names _____

NATURE OF ACCIDENT

- 1. Date of Accident _____ Time of day _____
- 2. Were you Driver Passenger Front Seat Back Seat
- 3. Number of people in the vehicle? _____ Were you wearing seat belts? _____
- 4. What direction were you headed? North East South West on (name of street) _____
- 5. What Direction was the other vehicle headed? North East South West on (name of street) _____
- 6. Were you struck from Behind Front Left side Right side
- 7. Approximate speed of your car _____ mph Other car _____ mph
- 8. Were you knocked unconscious? Yes No If yes, for how long? _____
- 9. What position was your head at the time Looking straight ahead Turned left Turned right
- 10. Were police notified? Yes No
- 11. In your own words, please describe the accident:

12. Did you have any physical complaints BEFORE THE ACCIDENT? Yes No If yes, please describe in detail:

- 13. Please describe how you felt:
 - a. DURING the accident _____
 - b. IMMEDIATELY AFTER the accident _____
 - c. LATER THAT DAY _____
 - d. THE NEXT DAY _____

14. Where were you taken after the CURRENT accident? _____

15. Have you been treated by another doctor since the accident? Yes No If yes, please list the doctor's name and address:

What type of treatment did you receive? (ex: MRI, X-Ray, Medication):

16. Since this injury occurred, are your symptoms Improving Getting Worse Same

17. Check symptoms you have noticed SINCE THE ACCIDENT

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Upset stomach |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above _____

18. What are your PRESENT complaints and symptoms:

19. Have you ever been involved in an accident before? Yes No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:

20. Do you have any previous illnesses which relate to this case? Yes No If yes, please describe:

21. Do you have any congenital (from birth) factors which relate to this problem? Yes No If yes, please describe:

22. Have you lost time from work as a result of this accident? Yes No If yes, please complete the following

a. Last day worked _____

b. Type of Employment _____

c. Present Salary _____

d. Are you being compensated for time lost from work? Yes No If yes, state type of compensation you are receiving:

23. Do you notice any activity restrictions as a result of this injury? Yes No If yes, please describe in detail:

24. Other pertinent information: _____

25. Please list all medications you are taking _____

26. List any types of surgeries and dates _____

27. Liquor consumed on a weekly basis? _____

28. Do you smoke? Yes No If yes, how much per day? _____

29. Any significant family medical history? _____

DATE

PATIENT'S SIGNATURE



OVIEDO INJURY & WELLNESS CENTER

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Oviedo, FL 32765
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HIPAA NOTICE OF PRIVACY PRACTICES FORM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

Notice to Individual:

The Practice is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your PHI. I have read them and declined the opportunity to read them and understand the Notice of Privacy Practices. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature _____

Date _____

Print Name _____

FOR PRACTICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this individual, but it could not be obtained because:

- The individual refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We were NOT able to communicate with the individual.
- Other (Please provide specific details):

Employee Signature _____

Date _____

THIS FORM WILL BE PLACED IN THE PATIENTS CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.
