

PATIENT REGISTRATION AND HISTORY

1 PATIENT INFORMATION	
Date: _____	
Name: _____ <small>Last Name First Name Initial</small>	
Address: _____ _____	
Home Phone #: _____	
Work Phone #: _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age: _____ Birth date: _____	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Social Security #: _____	
<i>IN CASE OF AN EMERGENCY, CONTACT</i>	
Name: _____	
Relationship: _____	
Home Phone #: _____	
Work Phone #: _____	
Occupation: _____	
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time Approx. Hours/week _____	
Employer: _____	
Employer Address: _____ _____	
Employer Phone #: _____	
Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of accident: <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	

2 INSURANCE INFORMATION
<u>Health Insurance:</u>
Insurance Co. _____
Phone # _____
Policyholder name: _____
Relationship to policyholder: _____
Policy #: _____
Group #: _____
<i>Complete the following if injury is related to an auto accident.</i>
<u>Motor Vehicle Insurance:</u>
Owner of vehicle in which you were injured: _____ _____
Insurance Co. _____
Phone # _____
Policy #: _____
Claim #: _____
Have you retained an attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____
Phone #: _____
<u>Third Party Information: (other vehicle that struck yours)</u>
Name: _____
Insurance Co. _____
Phone # _____
Policy #: _____
Claim #: _____

3 ACCIDENT INFORMATION	
Date of Injury: _____ Time: _____ AM/PM State: <input type="checkbox"/> DC <input type="checkbox"/> MD <input type="checkbox"/> VA <input type="checkbox"/> Other _____	
Describe in DETAIL how your injury occurred: _____ _____	
Were you the: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger Were you sitting in the: <input type="checkbox"/> Front Seat <input type="checkbox"/> Back Seat	
Were you struck from: <input type="checkbox"/> Behind <input type="checkbox"/> Front <input type="checkbox"/> Left Side <input type="checkbox"/> Right Side Were you wearing a seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you know you were going to be hit? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you brace for impact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Approximate speed your vehicle was traveling _____ mph OR were you stopped? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Approximate speed the other vehicle(s) were traveling _____ mph	
Make & Model of your vehicle _____ Make & Model of other vehicle _____	
Were police notified? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the police file a report? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What was the approximate damage to vehicle: <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Extensive <input type="checkbox"/> Totaled	
Amount of Damage \$ _____ Was your vehicle towed from the scene? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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PATIENT CONDITION

What are your present complaints? (location of pain, etc.)

Use an "X" on the drawing to mark where you are experiencing pain.

When did these symptoms first appear? _____

Does your pain interfere with: Sleep Daily routine Work Recreation

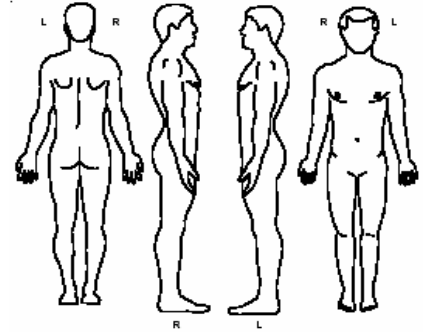
Are you working less hours/days as a result of your injuries? Yes No

If yes, please explain _____

Activities or movements that are painful to perform:

Sitting Standing Walking Bending Lying Down

Since the accident, are your symptoms: Improving About the same Getting Worse



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TREATMENT HISTORY

Have you been to the hospital for this condition? Yes No If yes, name of hospital? _____

When did you go? _____ How did you get there? Ambulance Self Others

Were radiographs taken? Yes No If yes, what area(s)? _____

Were you prescribed any medication? Yes No If yes, what medications? _____

Have you seen any other doctor or received any other treatment for your current condition? Yes No

If yes, explain _____

Doctor's name and address: _____

Phone #: _____ Date(s) seen: _____ Diagnosis: _____

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HEALTH HISTORY

INJURIES/SURGERIES you may have had.	Description	Date (s)
Auto Accident (s)	_____	_____
Work Injuries	_____	_____
Broken Bones	_____	_____
Surgeries	_____	_____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: (place "X" in boxes that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Muscle disorder | <input type="checkbox"/> Lungs, Asthma | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Nervous System Disorder | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizures/Convulsions` | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> HIV | <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hernias |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ears, eyes, nose, throat |
| <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Kidney, Bladder (GU) | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Stomach, Intestines (GI) | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Disease |

Female patients: Start date of most recent menstrual cycle: _____ Are you currently pregnant? Yes No

Doctor's name: _____ Phone #: _____

7**AUTHORIZATION FOR TREATMENT**

I hereby authorize the Doctor to treat my condition as he/she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid for the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while the patient is being treated at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. (The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Patient's
Signature: _____ Date: _____

Guardian's
Signature: _____ Date: _____