Patient Information

Date: ____________________

Name: ____________________

Address: ____________________ Birthday: ____________________

____

City State Zip

Phone #: ____________________

Cell #: ____________________

Work #: ____________________ Ext. ________

Best Time and Place to reach you ____________________

E-Mail (We will send you E-Newsletters): ____________________

Marital Status: ____________ # of Children: ____

Social Security #: ____________________

Occupation: ____________________

Employer: ____________________

Primary Care Physician

____

Address: ____________________

____

Phone: ____________________

Send report to PCP ☐

Reason for Visit (Major Complaint): ____________________

____

How long have you had this Condition? ____________________

Date Began: ____________

Have you lost work days? **Y** **N** How Many? ____________

Have you had a similar condition before? **Y** **N** When? ____________

Was the Injury related to: Work Accident Auto Accident Not related to Accident

Please mark to indicate if you have any of the following:

___AIDS/HIV
___Alcoholism
___Allergy Shots
___Anemia
___Anorexia
___Appendicitis
___Arthritis
___Asthma
___Bleeding Disorders
___Breast Lump
___Bronchitis
___Bulimia
___Cancer
___Cataracts
___Chemical Dependency
___Chicken Pox
___Diabetes
___Emphysema
___Epilepsy
___Fractures
___Glaucoma
___Goiter
___Gonorrhea
___Gout
___Heart Disease
___Hepatitis
___Hernia
___Herniated Disk
___Herpes
___High Cholesterol
___Kidney Disease
___Liver Disease
___Measles
___Migraine Headaches
___Miscarriage
___Mononucleosis
___Multiple Sclerosis
___Mumps
___Osteoporosis
___Pacemaker
___Parkinson's Disease
___Pinched Nerve
___Pneumonia
___Polio
___Prostate Problem
___Prosthesis
___Psychiatric Care
___Rheumatoid Arthritis
___Rheumatic Fever
___Scarlet Fever
___Stroke
___Suicide Attempt
___Thyroid Problem
___Tonsillitis
___Tuberculosis
___Tumors
___Typhoid Fever
___Ulcers
___Vaginal Infections
___Venereal Disease
___Whooping Cough
___Other ___________
____
____
____
____
____

Have you had any surgeries? ____

Are you currently taking any prescription or non-prescription medicine? ______________________

____

Have you seen any doctors for this condition? ____

Exercise	Work Activity	Habits
___None ___Moderate ___Daily ___Heavy	___Sitting ___Standing ___Light Labor ___Heavy Labor	___Smoking Packs/day________________ ___Alcohol Drinks/Week _______________ ___Coffee/ Caffeine Drinks Cups/Day ________________ ___High Stress Level Reason____________________

PERSONAL INJURY QUESTIONNAIRE

Date of Accident :________________

Where did accident happen? Describe the accident in your own words:

____

____

____

____

____

What was your position in the car?

☐ Driver: If Driver, were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both

☐ Passenger: If passenger, were you sitting in: ☐ Front ☐ Right Rear ☐ Left Rear

Did your vehicle strike another vehicle? ☐ Yes ☐ No

Was your vehicle stuck by another vehicle? ☐ Yes ☐ No

Angles of impact… First Collision: ☐ Front ☐ Back ☐ Left ☐ Right
If Second Collision: ☐ Front ☐ Back ☐ Left ☐ Right

Were you wearing a seat belt? ☐ Yes ☐ No
Did you brace for impact? ☐ Yes ☐ No … ☐ I braced with my hands ☐ I braced with my feet
Which way were you facing at the time of impact … ☐ Straight ahead ☐ Left ☐ Right

Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No
If yes, specify what part of your body struck what: ex … head, chest, chin, shoulder, right/left knee
☐ Steering Wheel ____________________ ☐ Dashboard ____________________
☐ Windshield ________________________ ☐ Roof __________________________
☐ Left Side Door _____________________ ☐ Right Side Door ____________________
☐ Left Side Window __________________ ☐ Right Side Window ___________________
☐ Other ____

Did the seat back bend or break? ☐ Yes ☐ No
Immediately following the accident, how did you feel? ☐ dizzy/dazed ☐ disoriented ☐ unconscious
☐ nervous ☐ nauseous ☐ upset ☐ weak ☐ Other ________________________

Did you go to the hospital? ☐ Yes ☐ No Were you admitted to the hospital? ☐ Yes ☐ No
If yes, how long? ____________ If you went to the hospital, when? ☐ At time of accident
☐ Next day
How did you get to the hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation
Name of Hospital: ____
Attended by Dr: ____
What treatment was given?
☐ None ☐ placed in a cervical collar ☐ X-rayed ☐ Given stitches ☐ Bandaged
☐ Given pain medication ☐ Given instructions regarding concussions
☐ Given instructions regarding sprains and strains ☐ Physical Therapy
☐ Instructed to call an Orthopedic Surgeon ☐ Instructed to call a private physician
☐ Referred to this office for treatment ☐ Other ____

Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No
Doctor's name _______________________________________
& Address: ____

CHIEF Complaints or Symptoms:

☐ NECK PAIN ☐ None ☐ Left Shoulder ☐ Left Arm ☐ Left Forearm
☐ Left Hand
Check of areas that the pain ☐ Right Shoulder ☐ Right Arm ☐ Right Forearm ☐ Right Hand

Runs into from the neck ☐ Headaches ☐ Migraine Headaches ☐ upper Back Pain

Ringing in Ears ☐ Yes ☐ No ☐ Left ☐ Right ☐ Both Ears

Blurry Vision ☐ Yes ☐ No ☐ Left ☐ Right ☐ Both Eyes

Wrist Pain ☐ **Yes** ☐ **No** ☐ **Left** ☐ **Right** ☐ **Both Wrists**

Jaw Pain ☐ **Yes** ☐ **No** ☐ **Left** ☐ **Right** ☐ **Both Sides**

☐ **Dizziness** ☐ **Nervousness** ☐ **Fatigue** ☐ **Anxiety** ☐ **Depression** ☐ **Excessive Irritability**
☐ **Fear of driving in a car** ☐ **A loss of concentration** ☐ **Jaw clenching** ☐ **Grinding Teeth**
☐ **Nightmares** ☐ **Difficulty with sleeping at night**

☐ **LOW BACK PAIN** ☐ **None** ☐ **Buttocks** ☐ **Left buttock** ☐ **Left thigh** ☐ **Left knee**
Select areas of radiation: ☐ **Left Foot** ☐ **Right buttock** ☐ **Right thigh** ☐ **Right knee** ☐ **Right foot**

Hip Pain ☐ **Left** ☐ **Right** ☐ **Bilateral**
Knee Pain ☐ **Left** ☐ **Right** ☐ **Bilateral**
Foot Pain ☐ **Left** ☐ **Right** ☐ **Bilateral**

NUMBNESS:
☐ **Left Hand** ☐ **Left Upper Arm** ☐ **Right Hand** ☐ **Right Upper Arm**
☐ **Left Foot** ☐ **Left Leg** ☐ **Right Foot** ☐ **Right Leg**

ADDITIONAL SYMPTOMS/COMPLAINTS:____
____
____
____
____
____

Have you lost any time from work due to your injuries? ☐ **Yes** ☐ **No**
If yes, please give dates: ____

Type of employment:____

ASSIGNMENT OF BENEFITS:

I certify that I have insurance coverage and assign directly to Dr. Robert J. Haley 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.

Signature: ____ Date: ____________________