

OKC WELLNESS CLINICS
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PATIENT INTAKE QUESTIONNAIRE

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Age: _____ Email: _____
H. Phone: (____) _____ C. Phone: _____ W. Phone: _____
Social Security #: _____ Driver's License #: _____
Occupation: _____ Employer: _____
Marital Status: M S D W SE Spouse Name: _____ Occupation: _____
Liability Insurance: _____ Insurance Address: _____
Adjustor: _____ Phone: _____ Fax: _____
Insured: _____ Insured's Policy #: _____
Patient Auto Insurance: _____ Pt. Insurance Address: _____
Patient Adjustor: _____ Phone: _____ Fax: _____
Patient Policy #: _____
Is Med Pay Available? Yes No
Patient Health Insurance: _____ Insurance Policy #: _____
Date of Accident: _____
Where did the accident happen? Describe the accident in your own words: _____

1. Did the pain begin gradually or suddenly? If gradually: few hours later, next morning, day, night, or following few days.
2. Are your symptoms/pain related to the above mentioned motor vehicle collision? Yes No
3. Can you describe the sensation you feel? (Dull, sharp, burning, aching, gnawing, throbbing, tingling, numbness, stiffness, tired, stabbing, shooting, radiating, etc.) Yes No
4. Has your condition been getting better, worse, or same? (circle one)
5. What makes it better? Inactivity/rest mornings evenings lying down getting up/down
 walking sitting standing movement/exercise bending lifting twisting nothing
6. What makes it worse? Inactivity/rest mornings evenings lying down getting up/down
 walking sitting standing movement/exercise bending lifting twisting nothing
7. Has your condition affected you daily activities? Yes No
If yes, how has it affected your daily activities? _____

MOTOR VEHICLE COLLISION QUESTIONNAIRE

1. 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
2. Did your vehicle strike another vehicle? Yes No
3. Was your vehicle struck by another vehicle? Yes No
4. Angles of impact... First Collision: Front Back Left Right
If Second Collision: Front Back Left Right
5. Were you wearing a seat belt? Yes No
6. Did you brace for impact? Yes No ... I braced with my hands I braced with my feet
7. Which way were you facing at the time of impact?... straight ahead Left Right
8. Did you strike anything in vehicle at time of impact? Yes No
If yes, specify what part of your body struck what: e.g.... head, chest, chin, shoulder, Right / Left Knee
 Steering Wheel _____ Dashboard _____

Windshield _____ Roof _____
 Driver Side Door _____ Passenger Side Door _____
 Driver Side Window _____ Passenger Window _____
 Other _____

9. Did the seat back bend / break? Yes No

10. Immediately following the accident, how did you feel? dizzy/dazed disoriented unconscious
 nervous nauseous upset weak Other _____

11. Did you go to hospital? Yes No Were you admitted to the hospital? Yes No if yes how long? _____
 If you went to hospital, when? At time of accident Next day Other _____
 How did you get to 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 a Doctor referred to this office for treatment
- Other _____

12. Have you seen any other doctor as a result of this accident? Yes No

Doctor's Name: _____

* Have you lost any time from work due to your injuries? Yes No

If yes please give dates: _____

If currently working, are you working light duty or regular duty? Are you working in pain or no pain?(circle one)

* Has there been any change in your bodily functions? (memory, vision, digestion, respiration, urination, defecation, dizziness, sexual, other) explain: _____

Severity of Pain

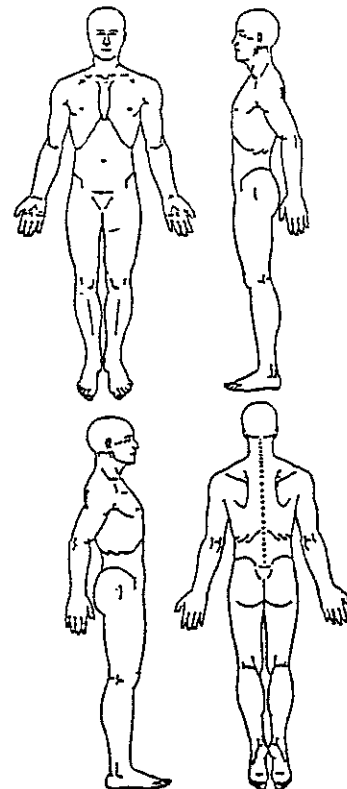
Circle Area(s) of Complaint:

List region of pain and circle severity

Number (1 = least, 10 = greatest)

Example: _____ Neck _____

- | | | | | | | | | | | |
|----|---|---|---|---|---|---|---|---|---|----|
| 1. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 6. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 7. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |



Patient Signature: _____ Date: _____