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: _____

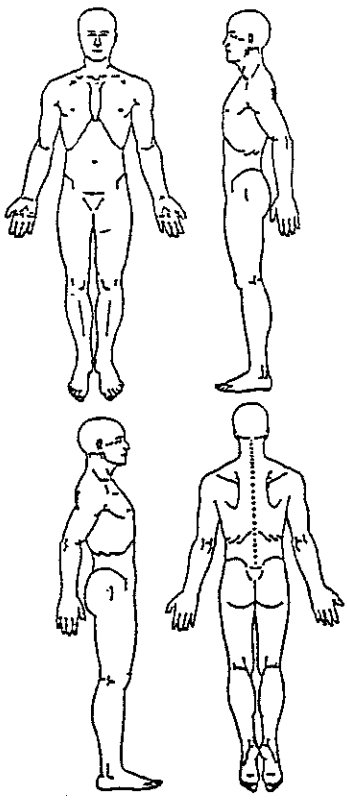
* Have you lost any time from work due to your injuries? Yes No
If yes please give dates: _____
If currently working, are you working light duty or regular duty? Are you working in pain or no pain?(circle one)
* Has there been any change in your bodily functions? (memory, vision, digestion, respiration, urination, defecation, dizziness, sexual, other) explain: _____

Severity of Pain
List region of pain and circle severity
Number (1 = least, 10 = greatest)
Example: _____ Neck _____

1 2 3 4 5 (6) 7 8 9 10

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

Circle Area(s) of Complaint:



Patient Signature: _____ Date: _____