OKC WELLNESS CLINICS
OKCWELLNESS.COM
PATIENT INTAKE QUESTIONNAIRE

Name:_____ Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Date of Birth:_____ Age:_____ Email:_____
H. Phone: (_____)_____-_____ C. Phone:(_____)_____-_____ W. Phone:(_____)_____-_____
Social Security #:_____-_____-_____ Drivers 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 gradual: a few hours later, the next morning, day, night, or the 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, tiredness, Stabbing, Shooting, radiating, etc.)___Yes ___No
   If yes, please describe:_____
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 your daily activities? ___Yes ___No
   If yes, how has it affected your daily activities?_____
_____

MOTOR VEHICLE 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 your seatbelt?___Yes ___No
6. Did you brace for impact?___Yes ___No
   If yes, ____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 the vehicle at the time of impact?___Yes ___No
   If yes, specify which part of your body struck what: (E.g., head, chest, chin, shoulder, right/left knee)

- ☐ Steering Wheel:_____
- ☐ Dashboard:_____
- ☐ Winshield:_____
- ☐ Roof:_____
- ☐ Driver Side Door:_____
- ☐ Passenger Side Door:_____
- ☐ Driver Side Window:_____
- ☐ Passenger Window:_____

☐ Other:_____

9. Did the seat bend/break? ___Yes No___

10. Immediately following the accident, how did you feel? ____Dizzy/Dazed ____Disoriented ____Unconcious ____Nervous ____Nauseous ____Upset ____Weak ____Other:_____

11. Did you go to the hospital?____Yes ____No

If yes, when? ___At time of accident ___Next day ___Other:_____

Were you admitted to the hospital? ____Yes ____No If yes, How long?:_____

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 Cervical Collar
- ☐ X-rayed
- ☐ Given stitches
- ☐ Bandaged
- ☐ Given pain medication
- ☐ Given instructions regarding concussions
- ☐ Given instructions regarding sprains/strains
- ☐ Physical Therapy
- ☐ Instructed to call a Dr.
- ☐ Referred to this office for treatment
- ☐ Other:_____

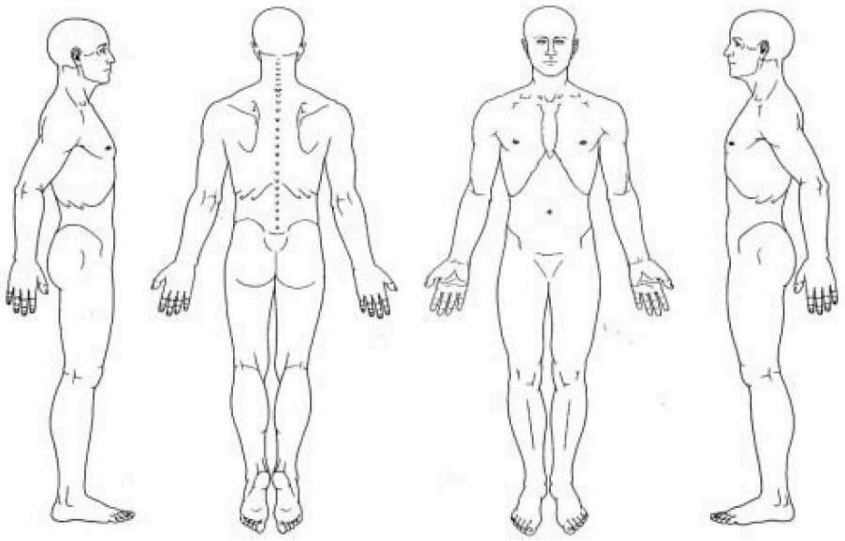
12. Have you seen any other Doctor as a result of this accident? ___Yes No___

If yes, provide the doctor's name:_____

- Have you lost 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:_____

_____

Circle Area/s of Complaint:



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

Consent to Marketing (Check One): ____Yes ____No

Patient Signature:_____Date:_____