# Auto Accident or Personal Injury
# Patient Health Questionnaire

**Name**: _____ **Nickname**: _____ **Date**:_____

**Age**: _____ **Date of Birth**: _____**Height**: _____ **Weight**: _____

**Occupation:**_____**Employer**:_____

**How did you hear about our facility?** [ ] Physician Referral [ ] You Are a Past Patient

[ ] Signage [ ] Friend or Family [ ] TV Commercial [ ] Website [ ] Other

**What was the exact date of your car accident**? Month _____ Day_____ Year_____

**Was the accident your fault?** [ ] Yes [ ] No

**How did the car accident occur**?_____

_____

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_____

**Was your car totaled?** [ ] Yes [ ] No

**Where did the accident occur?** [ ]City street [ ]Highway [ ]Stoplight or sign [ ] Intersection [ ]Other

**Where were you sitting at the time of the accident?** [ ] Driver [ ] Passenger [ ] Backseat

**Did you experience symptoms immediately after car accident?** [ ] Yes. If no when_____

**Have you received medical attention since the car accident?** [ ] Yes [ ] No

**If Yes Where?** [ ] Emergency Room [ ] Urgent Care [ ] Primary Care [ ] Chiropractor

[ ] Orthopedist [ ] Other Name of physician or facility? _____

**Have you undergone diagnostic imaging since the accident**? [ ] Yes [ ] No

**If Yes What**? [ ] X-rays [ ] CT scan [ ] MRI [ ] Other_____

**If Yes, what body part? _____ What facility?_____**

**Did you have surgery for this condition**? [ ] Yes, [ ] No Surgeon Name _____

**Date of surgery**: Month _____ Day_____ Year_____

**Did you have previous problems with your injury before the car accident**? [ ] Yes [ ]No

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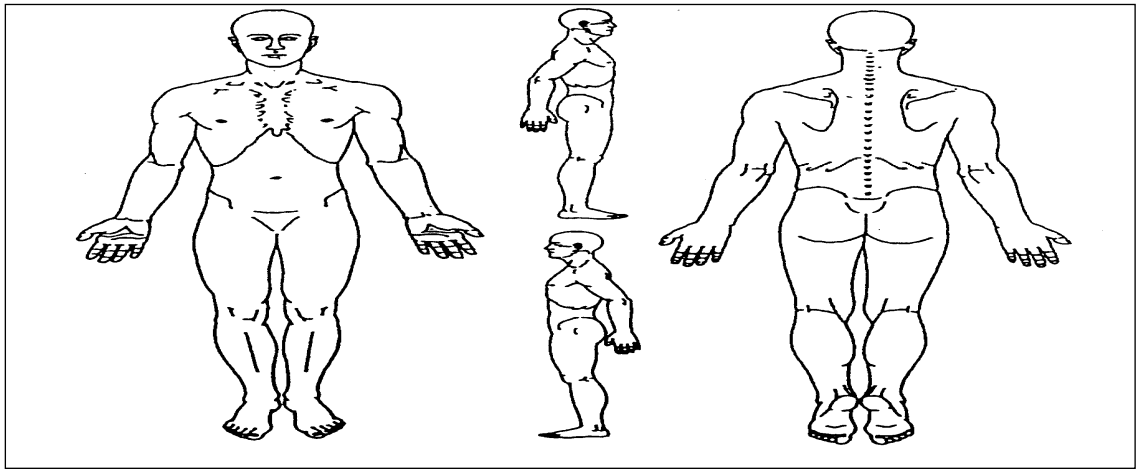
***On below chart please mark (X) location of your injury**:



**Please rate your pain on a scale of 0 – 10 with (0) being no pain and (10) being the worst**.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| At Worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Current: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At Best: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Aggravating Factors**: [ ] Sitting, [ ] Standing, [ ] Walking, [ ] Stairs, [ ] Sit to stand, [ ] Bending,

[ ] Lifting, [ ] Sleeping, [ ] Squatting, [ ] Carrying, [ ] Reaching Overhead, [ ] Handling objects,

[ ] Pushing, [ ] Pulling, [ ] Running, [ ] Jumping, [ ] Exercise

**Medications you are taking related to your injury**: [ ] Prescription pain, [ ] Over the counter pain,

[ ] Anti-inflammatory, [ ] Other _____

**Check if you have, or have ever had any of the following conditions**:

[ ] Abdominal Aneurysm, [ ] Pacemaker, [ ] Diabetes Type 1, [ ] Diabetes Type 2 [ ] Stroke

[ ] High Blood Pressure, [ ] HIV (+), [ ] Heart Attack, [ ] Fibromyalgia, [ ] Rheumatoid Arthritis,

[ ] Osteo Arthritis [ ] Currently Pregnant [ ] Cancer, What type_____ [ ] Are you in remission

**Please list other pertinent medical conditions that might affect your treatment**:

_____

## Patient Name:_____

# PHYSICAL THERAPY SPECIALISTS
## Patient Information

_____ _ _ _____/___/__ _____
Patient First Name Middle Initial Last Name Gender Date of Birth Age Marital Status

_____
Street Address City State Zip

(____) _____-_____(____)_____-_____ _____-_____-_____
Cell Phone number Home Phone Number E-mail Address Social Security Number

**If you like to receive a reminder by text, email or voice call for your visits please circle one: Text E-mail Voice**

_____(____)_____-_____
Emergency Contact Name Relation to Patient Phone Number

_____(____)_____-_____
Patient Employer's Name Employer's Phone

_____(____)_____-_____
Name of Primary Care Physician Primary Care Physicians Phone Number

_____(____)_____-_____
Referring Doctor Referring Doctor Phone Number

_____
How did you hear about our facility?

**SPOUSE/ PARENT** *(IF NOT MARRIED)* **INFORMATION**

_____/___/_____
Last Name First Name Initial Date of Birth

***** Is my referral due to a Workers Comp, Auto Accident, or Slip and Fall Personal Injury?**
**Yes No Circle one of the above if Yes**

**RESPONSIBILITY STATEMENT & RELEASE OF INFORMATION**
**I understand that I am responsible for paying for all medical services not covered by an authorization/agreement between Physical Therapy Specialists and my insurance carrier or attorney.** I authorize the release of any or all of the patient's medical records for this period of care to any person/corporation liable for any part of the physician charges and the patient's attorney. Oklahoma state law requires that we advise "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS)."

_____
Print Patient or Legal Guardian Name

_____
Patient or Legal Guardian Signature Date

# Physical Therapy Specialists
# Auto Accident or Personal
# Injury Questionnaire

**Please fill in <u>all</u> blanks.**

_____

Patient last name First name Middle initial Date of injury

_____

Location of accident (including City and State)

**<u>Please answer the following questions in full :</u>**

Do you have med-pay coverage?_____ If so, how much_____

Do you have uninsured or underinsured motorist coverage?_____

_____

Insurance company name **(Your Car)** Policy number Claim number

_____(____)_____

Policyholder's name (from card) Insurance Phone Number

Were you on the job during the accident? **Circle one** Yes No

Damage to your car $_____ Totaled? **Circle one** Yes No

Year & Model of your car_____

**Liability Insurance Information**:

_____

Insurance Company name **(Other car)**Policy number Claim number

_____(____)_____

Policy holder's name (from card) Insurance Phone Number

Do you have an Attorney? _____ If so, provide all the information below.

_____(___)_____-_____

Attorney name Attorney phone number

_____

City & State

9716 Riverside Parkway, Suite 201, Tulsa OK 74137 & 8165 S. Mingo Road, Suite 101, Tulsa OK 74133
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