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

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

Patient Information

***** 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

*****Please present your insurance card to the receptionist when you hand in your paper work. Thank you.*****

Primary Insurance Company Name	Policy Number	Group Number
Policy Holder's Name (from card)	Social Security Number	Date of Birth
Secondary Insurance Company Name	Policy Number	Group Number
Policy Holder's Name (from card)	Social Security Number	Date of Birth

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

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>The following questions must be answered in full please:</u>

Do you have Health Insurance? _____ Do you have auto insurance? _____

_____

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

_____(____)_____

Policy holder'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_____

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

Do you have uninsured or underinsured motorist coverage?_____

Have you informed your auto insurance of this accident? **Yes or No** When_____

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

_____(___)_____-_____

Attorney name Attorney phone number

_____

Attorney address

_____(___)___-_____

City State Zip Attorney fax number

_____

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

_____(____)_____

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

9716 Riverside Parkway, Suite 201, Tulsa OK 74137 & 8165 S. Mingo Road, Suite 101, Tulsa OK 74133
Phone 918-615-6280 Fax 918-615-6240

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 [ ] Past Patient [ ] Internet

[ ] Signage [ ] Friend or Family [ ] Attorney [ ] Other _____

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

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

Who was ticketed for the car accident? _____ *Please provide our office with a copy of the police report.*

How did the car accident occur?_____

_____

_____

_____

_____

Was your car totaled? [ ] Yes [ ] No

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

Were you wearing your seatbelt? [ ] Yes [ ] No

Did your body hit anything in the car upon impact? _____

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

physical therapy specialists

Auto Accident or Personal Injury
Patient Health Questionnaire

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

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

What were the results of the Imaging? [ ] Fracture [ ]Soft Tissue Injury [ ] Disc injury [ ]Unknown
Please provide our office with any copies of Dr. visits and imaging reports.

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

Date of surgery: Month _____ Day_____ Year_____

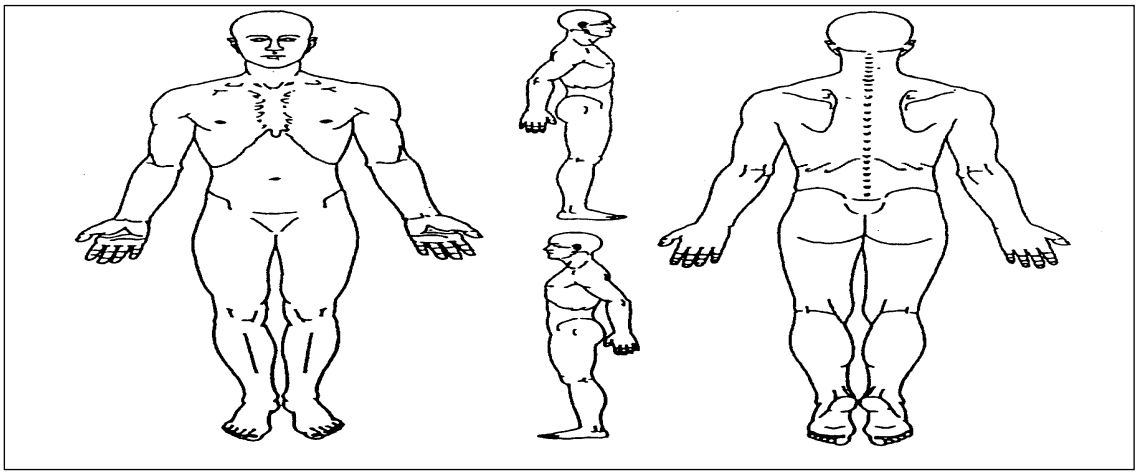
Did you have previous problems with your injury before the car accident? [ ] Yes [ ]No

What other treatment are you currently receiving for this condition? [ ]Medication [ ]Injections

[ ] Chiropractic [ ] Other _____

Since the injury are your symptoms getting [ ] Better? [ ] Worse? [ ] Same?

***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

Patient Name:_____

Auto Accident or Personal Injury
Patient Health Questionnaire

Describe your pain: (Mark only the **one** that best describes)

[ ] Sharp, [ ] Dull / Achy, [ ] Burning, [ ] Shooting, [ ] Numbness/Tingling, [ ] Constant,

[ ] Intermittent [ ] Worse in am, [ ] Worse in pm

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

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

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

Alleviating Factors: [ ] Sitting, [ ] Standing [ ] Walking, [ ] Lying Down, [ ] On the move,

[ ] When still, [ ] As the day progresses

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:

_____

What is your primary goal in Physical Therapy:_____

_____

_____

Patient Name:_____