INJURY REHABILITATION CENTERS OF CENTRAL FLORIDA

2639 West S.R. 434 Longwood, Fl 32779

WELCOME TO OUR TREATMENT CENTER! To help us provide you with the best possible care, please provide the following information:

Name: _____ **Today's Date:** _____

Address: _____ **Marital Status:** _____

City: _____ **State:** _____ **Zip Code:** _____

DOB: _____ **Social Security #:** _____

Phone Numbers: **Home:** _____ **Work:** _____
Cell: _____ **Email:** _____
Emergency Contact: _____ **Phone:** _____

Employer: _____ **Phone:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____

ACCIDENT INFORMATION:

Date of Accident: _____ Time: _____AM/PM

Location: _____

Were you the driver _____ or the passenger _____

Were you wearing a seat belt ___ yes ___ no

Did you go to the hospital following this accident? _____
If yes, which hospital? _____

What type of treatment did you receive?_____

INSURANCE INFORMATION:
Insurance Company Name: _____ Phone: _____
Claim Number: _____ Adjustor: _____

Do you have an attorney? _____
Name: _____
Address: _____
_____
Phone Number: _____ Fax Number: _____

ACCIDENT INFORMATION

Date of Accident: _____ Time: _____

Where were you sitting in the vehicle? _____
(Driver, front seat passenger, etc)

What type of vehicle where you in? _____
(Make and Model)

Make and model of the other vehicle(s)? _____

At what speed was your vehicle traveling? _____

Was your vehicle accelerating? Yes _____ No _____

What was your vehicle doing immediately prior to impact? _____
(i.e. Changing lanes, stopped, turning)

What was your vehicle's point of impact? _____
(i.e. front bumper, rear bumper, front fender, etc)

What was the amount of damage to your vehicle? _____ Was another vehicle involved? Yes _____ No _____

Describe the accident:

_____

_____

_____

Did the police fill out an accident report? Yes _____ No: _____

Does your vehicle have airbags? Yes _____ No _____ If yes, did the airbags deploy? Yes_____ No _____

Was your headrest properly adjusted? Yes _____ No: _____

Does your seatbelt have a shoulder harness? Yes _____ No: _____

Was your foot on the brake at the time of impact? Yes _____ No _____ Don't remember
If yes, was foot knocked off the brake at the time of impact? Yes _____ No _____

What was the position of your head/neck at the time of impact? _____

Did you lose consciousness at the time of impact? Yes _____ No _____

Did you receive emergency care at the scene? Yes _____ No _____

Did any part of your body strike any part of your vehicle upon impact? Yes _____ No _____

MEDICAL CHECKLIST

Allergies: Please list any allergies to medications: _____

_____

Present Medications: _____

Past Medical History: _____

Family History: _____

Prior Surgeries: _____

Prior Orthopedic treatment: _____

Prior Chiropractic treatment: _____

Name of Family Physician: _____

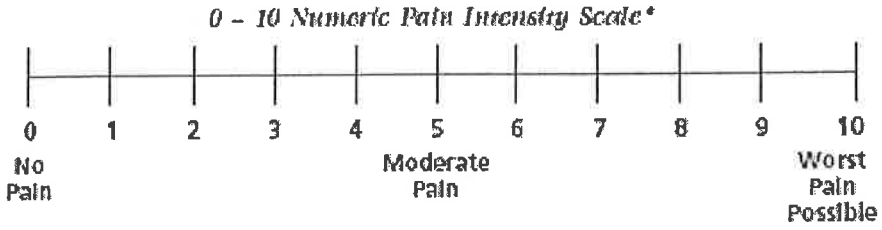
When was your last medical check-up? _____

Have you experienced any of the following since your injury?

___ Dizziness ___ Blurred Vision ___ Loss of Memory

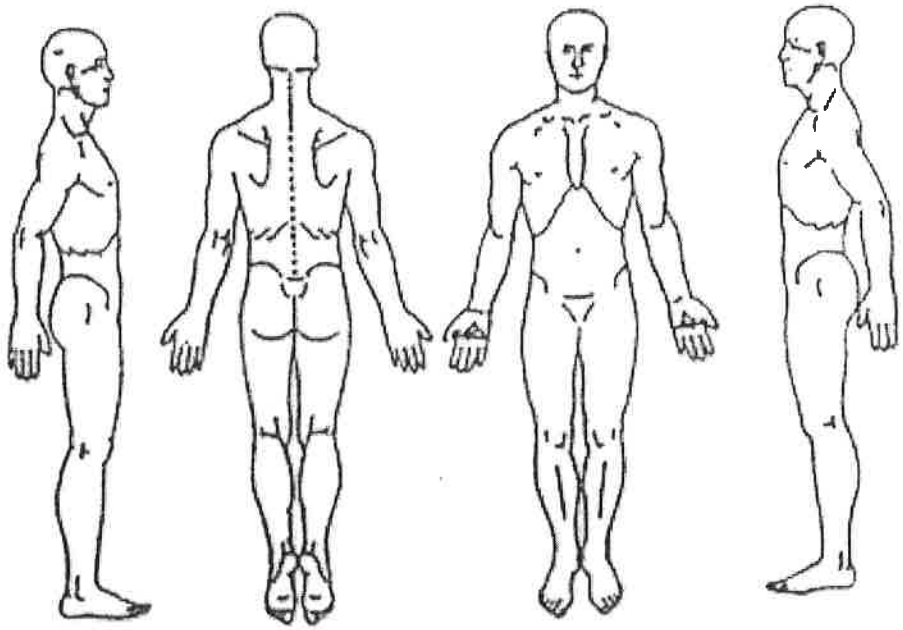
___ Difficulty Breathing ___ Confusion ___ Bleeding

What is your pain level today?



Please use the following letters to indicate the location and type of symptoms you are having

A = Aching
B = Burning
T = Tingling
S = Stabbing
N = Numbness
H = Heaviness
W = Weakness
P = Pressure
O = Other



Did you miss any time from work due to your injuries? Yes _____ No _____
If yes, what dates? _____

Do you smoke? Yes _____ No _____

Do you drink alcohol? Yes _____ No ____

Are you pregnant? Yes _____ No _____

I HEREBY STATE THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____
Signature of patient

_____
Print Name

INJURY REHABILITATION CENTERS OF CENTRAL FLORIDA

2639 W STATE RD 434, LONGWOOD, FL 32779
Phone: (407) 622-6590 Fax: (407) 622-6590

Patient Medical History

Patient Name: _____ Patient Account# _____

Please list all prior surgeries and approximate dates: _____
_____

Do you suffer from dizziness? **Yes** or **No**
Do you have history of cancer? **Yes** or **No**
Are you diabetic? **Yes** or **No**
Are you allergic to latex? **Yes** or **No**
Is there a possibility of pregnancy at this time? **Yes** or **No**

Mark YES (Y) or NO (N) on each line:

___ Cardiac pacemaker
___Aneurysm clip(s)
___Cardiac Defibrillator
___Neurostimulator
___Hearing aid
___Any type of implant: Please Describe_____
___Artificial limb or joint
___Any type of surgical clips or staples
___Any type of foreign body, shrapnel or bullet
___Wire mesh
___Stent, filter or intravascular coil
___Screw
___Other_____

I HERBY STATE THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

Patient/Guardian_____ Date: _____