INJURY REHABILITATION CENTERS OF CENTRAL FLORIDA

2639 W. State Road 434
Longwood, FL 32779
Phone : 407-622-6590 Fax : 407-622-6592

Demographic Information:

Today's Date: _____

Name: _____ DOB: _____ Gender: M or F

SSN: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____

Address_____

City: _____ State: _____ Zip: _____

Email: _____

Auto Insurance:

Insurance Company Name: _____

Name of Insured: _____ Relationship to Patient: _____

Policy #: _____ Claim #: _____

Attorney Information:

Name of Firm: _____

Attorney's Name: _____ Phone:_____

Address: _____

City: _____ State: _____ Zip: _____

Social History: (Circle all that apply to you)

Caffeine use: Always Occasional Never

Drink Alcohol: Always Occasional Never

Exercise: Always Occasional Never

Chew Tobacco: Always Occasional Never

Cigarettes: <1 pack/day >1 pack/day Never

Other: _____

Medical Conditions: (Check all that apply to you)

__ Arthritis __ Cancer __ Diabetes __ Heart Disease

__ Hypertension __ Psychiatric Illness __ Skin Disorder __ Stroke

__ HIV __ AIDS __ Hepatitis A B C __ MRSA

Other: _____

Surgeries: (Check all that apply to you)

__ Appendectomy __Knee __ Cervical Spine __ Hysterectomy

__ Joint Replacement __ Prostate __ Thoracic Spine __ Gall Bladder

__ Brain __ Shoulder __ Lumbar Spine __ Uro – Genital

__ Carpal Tunnel __ Hernia __ Cardiovascular procedure __ Gastro-Intestinal

Other: _____

Allergies: (Check all that apply to you)

__ Eggs __ Fish and Shellfish __ Milk or Lactose __ Peanuts

__ Soy __ Sulfites __ Wheat/Glutens __ Latex

Other: _____

Is it possible you could be pregnant? ___ Yes or ___ No

Did you receive emergency care at the scene? ___Yes or___ No.

If no, did you go to the hospital? ___Yes or ___No

Name of Hospital: _____

Did you have:

X-rays: ___ Yes or ___ No CT Scans: ___ Yes or ___ No MRIs: ___ Yes or ___ No

Have you been treated at any other facility for this accident? __ Yes or __ No

If yes, please explain: _____

Where you given any medications? __ Yes or __ No. If yes, which ones: _____

Did you miss any work? Yes or No If yes, give dates: _____

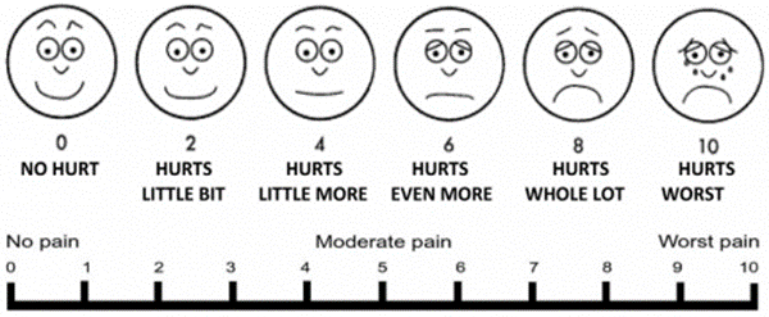
I HEREBY STATE THAT THE INFORMATION PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE.

Patient/Guardian Signature: _____ **Date**: _____

Printed Name: _____

Patient Name: _____

What is your pain level today?



Have you experienced any of the following since your injury? (Check all that apply to you)

__ Dizziness __Blurred Vision __ Loss of Memory

__ Difficulty Breathing __ Confusion __ Bleeding

Mark Yes (Y) or No (N) on each line:

___ Cardiac Pacemaker

___ Aneurysm Clip(s)

___ Cardiac Defibrillator

___ Neurostimulator

___ Hearing Aid

___ 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

___ Any type of implant? Describe: _____

___ Other (Please Describe): _____

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

Patient/Guardian Signature: _____ **Date:** _____

Accident Information

Type of accident (circle one): Auto Accident Slip & Fall Workers Comp

Date of Accident: _____ Time: _____ Location: _____

Where you the DRIVER or PASSENGER (please circle one).

Your vehicle: Make: _____ Model: _____

Was another vehicle involved? ___ Yes or ___ No

Other vehicle(s): Make: _____ Model: _____

Was your vehicle accelerating? ___ Yes or ___ No

If yes, at what speed was your vehicle traveling? _____

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

_____

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? _____

Did the police fill out an accident report? ___ Yes or ___ No

Does your vehicle have air bags? ___ Yes or ___ No

If yes, did the airbags deploy? ___ Yes or ___ No

Was your headrest properly adjusted? ___ Yes or ___ No

Does your seatbelt have a shoulder harness? ___ Yes or ___ No

Was your foot on the brake at the time of impact? __ Yes or __ No or __ Don't remember

If yes, was your foot knocked off the brake at the time of impact? ___ Yes or ___ No

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

Did you lose consciousness at the time of impact? _____

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

Describe the accident:

_____

_____

_____

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

_____ _____

Patient/Guardian Signature **Date**