INJURY TELEHEALTH, LLC

www.injurytelehealth.com

Personal Injury/Accident Medical History Intake Form

Referred by:_____ Account No.:_____ Date:_____

Full Name: _____

(Mark a ✓ on each that applies)

Gender: ☐M ☐F *Marital Status:* ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced **Age:**_____

Birth Date:___/____/_____ Height _____ Weight _____

Address: _____

City:_____State:_____ Zip:_____

Social Security No. _____ Driver's License No.:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Who Referred you: _____

Employer:_____ Work Phone: (_____) _____

Email: _____

Insurance / Attorney Information:

Insured's Name: _____
(Last) (First) (Init)

Relation to patient: _____ D.O.B.: _____ Soc. Sec. #: _____

Insurance Company: _____

ID#:_____ Group #: _____

Do you have MedPay? ☐ Yes ☐ No Were you at fault? ☐ Yes ☐ No

Have you retained an attorney? Yes / No

Your Attorney's Name: _____

Your Attorney's Phone: (____)_____ Fax (_____) _____

Your Attorney's Address: _____

City: _____ State: _____ Zip: _____

Accident Information:

Date of Accident:_____/_____/_____ Time of Accident:_____a.m. / p.m.

Your Vehicle: Year _____ Make_____ Model_____

Other Vehicle: Year _____ Make _____ Model_____

Seat Belt: ☐ Yes ☐ No Accident Type: ☐ Rear ended ☐ Head-on ☐ Broad-sided

Damage to Your Vehicle: $_____ Other Vehicle Damage: $ _____

Describe Accident: _____

_____

Accident Specifics: (Mark a ✓ on each that applies to the accident)

Was this injury accident related? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Other

Was this a Job or Work related injury: ☐ Yes ☐ No Were you the: ☐ Driver ☐ Passenger

If passenger, where were you sitting: ☐ Front Seat ☐ Back Seat

Were you wearing your seatbelt: ☐ Yes ☐ No Did the airbag deploy: ☐ Yes ☐ No

Impending Collision, were you: ☐ Aware ☐ Unaware ☐ Braced ☐ Not braced

Did your head: ☐ Strike Object ☐ Not strike Object ☐ Break Glass ☐ Other

Did you experience: ☐ Shock ☐ Loss of Consciousness ☐ Whiplash ☐ Other

The Weather Conditions were they: ☐ Sunny ☐ Raining ☐ Snowing ☐ Foggy

The Road was: ☐ Dry ☐ Wet ☐ Icy Time of Day: ☐ Dawn ☐ Day ☐ Dusk ☐ Night

State your emotions and physical state immediately following the accident: _____

_____

State your emotions & physical state after the first few days: _____

_____

Immediately Following The Accident: (Mark a ✓ on each that applies to the accident)

☐ Ambulance / Paramedics were called ☐ I was treated at the scene

☐ I was transported to Hospital by Ambulance ☐ I went to Hospital in my own

☐ I was diagnosed at the Hospital ☐ I was treated at the Hospital

☐ Medication was prescribed ☐ Follow-up was recommended

Other Doctors Seen:

☐ Orthopedist ☐ Neurologist ☐ Psychiatrist ☐ Physiatrist ☐ Chiropractor

☐ Acupuncturist ☐ General Practitioner ☐ Physical Therapist ☐ Massage Therapist

☐ Other

Symptomatology: (Pain characteristics for major area of complaint)

The pain started: _____

_____

The pain is made **better** by: _____

_____

and **worse** by_____

_____

There is / There isn't **radiation** into: _____

_____

There is / There isn't **parentheses (tingling/numbness)** into: _____

_____

The pain is **located**: _____

_____

The pain is (as far as timing is concerned: i.e. comes & goes, constant, etc.):_____

_____

Daily Activities:

How many days out of an average week do you have pain? ☐ >1 ☐ 2-5 ☐ 5-7

How much time out of an average day are you in pain? ☐ Always ☐ Sometimes ☐ Never

What are the worst times of day for the pain? ☐ Morning ☐ Noon ☐ Evening ☐ Other

When do you feel the best? ☐ Morning ☐ Noon ☐ Evening ☐ Other

Pain Rating:

On a scale of 0 – 10, rate your pain: (Please circle the number that best describes your pain)

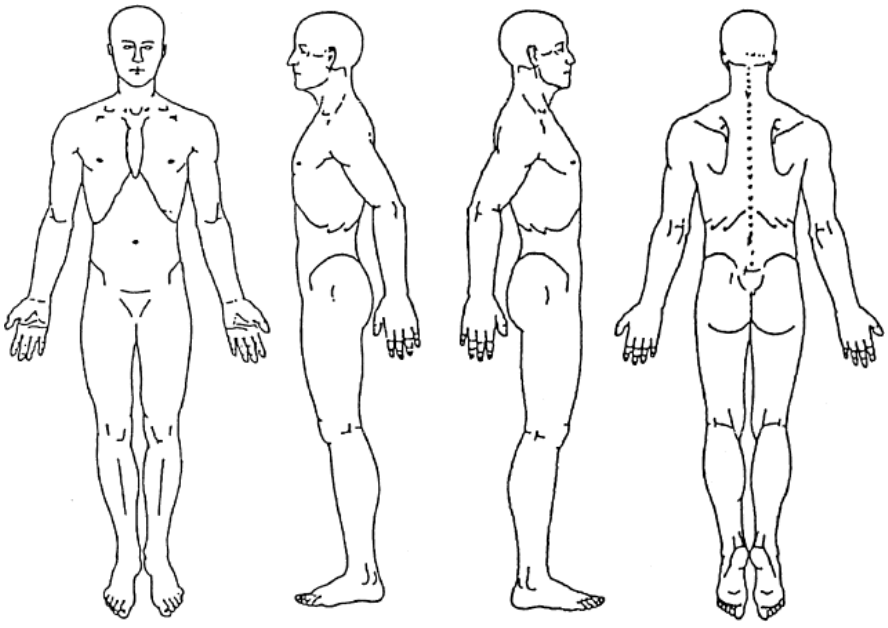
No Pain **Severe Pain**

0 1 2 3 4 5 6 7 8 9 10

Please use the legend symbols below to accurately mark the areas in which you feel these sensations:

Stabbing/Cutting-//// Tingling-**** Burning-XXXX Cramping- ^^^^

Numbness-NNNN Dull-####



Describe the overall severity of the pain:

☐ Mild Nuisance ☐ Mild to moderate, but can live with it

☐ Moderate, having trouble coping with it ☐ Severe, it is ruining my quality of life

How do the following activities affect your pain?

	No Change	Relieves	Increased	Duration
Sitting	☐	☐	☐	_____
Walking	☐	☐	☐	_____
Standing	☐	☐	☐	_____
Lying	☐	☐	☐	_____
Down	☐	☐	☐	_____
Looking up	☐	☐	☐	_____
Looking Down	☐	☐	☐	_____
Lifting	☐	☐	☐	_____

Progression:

How is your pain compared to when the pain episode first started?

☐ Much Improved ☐ Somewhat Improved ☐ Much Worse ☐ Somewhat Worse ☐ No Change

What do you do to relieve the pain? _____

_____

Please mark a ☐ on each that applies to your daily activities:

☐ Have difficulty climbing stairs.

☐ Have to use handrails to get up stairs, etc.

☐ Have to hold onto something to sit or stand from a chair. Stay at home most of the time.

☐ Do not do jobs around the house. Walk slower than usual.

☐ Can only walk short distances. Have to sit most of the day.

☐ Can only stand for short periods of time. Stays in bed most of the day.

☐ Change position frequently to try and get comfortable. Have difficulty turning over in bed.

☐ Have to lie down and rest frequently. Have difficulty sleeping.

☐ Have to get other people to do things for me. Have difficulty getting dressed.

☐ Have to get dressed with someone's help. Have difficulty bending or kneeling.

☐ Have a loss of appetite. Have more irritable stages.

What are some recreational activities that you participated in before this current problem and which ones cannot be performed now to the same extent as before? _____

_____

How often do you have to stop activities and sit or lie down to control your symptoms?

☐ Several Times ☐ Occasionally ☐ Approximately_____per day ☐ Never All Day

List your hobbies & exercise activities ? _____

_____

Social History:

☐ Smoker ☐ Non-Smoker ☐ Do not drink alcohol ☐ Drink alcohol

How much?_____ How often? _____

☐ Do not take drugs ☐ Take Drugs How much?_____ How often?_____

Number of Children:_____

Medical History:

List any medical professionals you have seen for this problem: _____

List any medications you are currently taking: _____

_____

List the treatments you have had for your problem:

☐ Chiropractic ☐ Osteopathy ☐ Trigger Point Injections ☐ Epidural Injections

☐ Acupuncture ☐ Hot packs ☐ Ultrasound ☐ Massage

☐ Electrical Stimulation ☐ Strengthening Exercises ☐ Aerobics

☐ Bed Rest ☐ Back Brace Other: _____

List the types of Diagnostic Testing that has been performed for this problem:

☐ X-Rays ☐ C.T. Scan ☐ M.R.I. Scan ☐ Discogram ☐ Bone Scan ☐ E.M.G.

List Past Surgeries: ☐ None

_____

_____

List Past Hospitalizations: ☐ None

_____

_____

List previous back, neck and musculoskeletal problems:

_____

_____

Medical History:

Do you have or have you ever had diseases or conditions of (please check Yes ☐ or No ☐)

Respiratory:

Bronchitis	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐
Asthma	Yes ☐ No ☐
Chronic Cough	Yes ☐ No ☐
Morning Cough	Yes ☐ No ☐
Shortness of Breath	Yes ☐ No ☐
Wheezing	Yes ☐ No ☐

Cardiovascular:

High Blood Pressure	Yes ☐ No ☐
Chest Pain	Yes ☐ No ☐
Heart Attack	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐
Arrhythmia	Yes ☐ No ☐
Phlebitis	Yes ☐ No ☐
Hardening of the Arteries	Yes ☐ No ☐
Artificial Valve	Yes ☐ No ☐
Pacemaker	Yes ☐ No ☐

Other Systemic:

Hepatitis	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐
Thyroid Problems	Yes ☐ No ☐
Kidney Disease	Yes ☐ No ☐
Dialysis	Yes ☐ No ☐
Bladder Problems	Yes ☐ No ☐

Gastrointestinal

Stomach absorptive disorder	Yes ☐ No ☐
Nausea, vomiting, diarrhea when taking antibiotics	Yes ☐ No ☐
Yeast infection when taking antibiotics	Yes ☐ No ☐
Arthritis/joint Deformity	Yes ☐ No ☐
Artificial Joint	Yes ☐ No ☐
Convulsions	Yes ☐ No ☐
Epilepsy, Seizures	Yes ☐ No ☐
Fainting	Yes ☐ No ☐

Do you have any current problems with:

☐ Anxiety ☐ Depression ☐ Irritability ☐ Other: _____

Do you have a home exercise program that you follow on a regular basis?

☐ Yes ☐ No

Notes:

_____

_____

_____

_____

_____ _____

Signature Date