Patient Information

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THE FOLLOWING INFORMATION IS CRITICALLY IMPORTANT.
You must bring this complete form to your appointment. Please do not have any item blank.

Name_____ Date_____
Address_____
City_____ State_____ Zip_____ Phone_____
Date of Birth_____ Age_____ __Male __Female
Email address_____

Attorney *(please attached a business card if possible)*

Attorney's Name_____ Phone_____
Address_____
City_____ State_____ Zip_____ Phone_____
Email address_____

Personal Injury / Motor Vehicle Accident Information

Date of Injury_____ Location of Accident_____
Insurance Co..._____Insured (person/business)_____
Claims Adjustor_____Phone_____ Claim#_____

Responsible Party Information *(if different from above)*

Name_____ SSN_____
Address_____ Phone_____
Employer_____ Phone_____

Employment

Employer_____ Phone_____
Address_____ Fax_____
City_____ State_____ Zip_____

Emergency Notification

Name_____ Relationship_____
Address_____ Phone_____
City_____ State_____ Zip_____

Job Description

Job Title_____ __ Right handed __ Left handed
Job Description_____
# of hours per day_____ # of days per week_____ Overtime? __Yes __No
Duties/Tools used_____
_____
_____
How many pounds do you lift at work? _____ How long have you been in this line of work? _____
Do you use any safety equipment/shoe wear? _____
Did you work somewhere else at the same time? If so, where?_____
Have you returned to work since the accident? __Yes __No

History of Injury

Date of Injury_____
Where did injury occur?_____
What body part(s) were injured? _____
Have you ever injured this leg/foot/ankle before? __Yes __No
What type of shoes were you wearing? _____

How did the injury occur? _____
_____
_____
_____
_____
_____

Initial Symptoms ***(please describe in your own words)***

_____
_____
_____
_____

Initial Treatment

Doctor's Name_____ Date seen_____
What was your diagnosis?_____
_____
Were x-rays taken? __Yes __No
What medications were you given?_____
Were you given: __Splint __Cast __Crutches __Braces __Orthotics or shoe inserts
Other?_____

Second Physician

Doctor's Name_____ Date seen_____
What was your diagnosis? _____
_____
Were x-rays taken? __Yes __No
What medications were you given?_____
Were you given: __Splint __Cast __Crutches __Braces __Orthotics or shoe inserts
Other?_____

Third Physician

Doctor's Name_____ Date seen_____
What was your diagnosis? _____
_____
Were x-rays taken? __Yes __No
What medications were you given?_____
Were you given:: __Splint __Cast __Crutches __Braces __Orthotics or shoe inserts
Other?_____

Current Symptoms

_____
_____ _____
_____
Are symptoms increased or decreased by the following and how?
Standing _____
Walking _____
Running _____
Uneven ground _____
Going up stairs _____
Going down stairs _____
Squatting _____
Driving _____
Sleeping _____
Elevation _____
Ice _____
Heat _____
Weather change _____
Shoes _____
Compression Stockings_____

Activities that you are no longer able to do:

_____
_____
_____
_____

Current Medication:

Current medications (for this problem only):

_____
_____

Work History:

Time off work (dates)_____
Time performing modified duty_____
Have you returned to regular duty? __Yes __No if yes date?_____

Was this work-related? __Yes __No
Have you had any prior work-related injuries? __Yes __No
If yes, what was injured? _____

Currently working for? _____

Please list your employment for the past 5 years, most recent first:
Employer_____ Position_____ Years_____
Employer_____ Position_____ Years_____
Employer_____ Position_____ Years_____

GENERAL HEALTH

Height _____ ft _____ in Weight_____
__Right Handed __Left Handed
Are you healthy? __Yes __No
Do you have a birth defect? __Yes __No
Do you limp? __Mild __Moderate __Severe
Do you use: __Cane __Crutch __Walker
Do you have metal in your body? __Yes __No
Do you have a pacemaker? __Yes __No
Do you: __Smoke __Drink Alcohol
Do you have allergies?
Have you had prior surgery?_____
Have you had prior hospitalizations?_____

REVIEW OF SYSTEMS

__Migraine headaches	__Blood clots in legs	__Vision trouble	__Pneumonia
__Recent severe headaches	__Bleeding disorders	__Hearing difficulty	__Shortness of breath
__Blackouts or fainting spells	__Glaucoma	__Emphysema	__Chest pain
__Convulsions or epilepsy	__Frequent cough	__Stroke or paralysis	__Conjunctivitis

FAMILY HISTORY ***(please describe any conditions you have associated with the following)***

Mother: __Alive __Deceased/Age_____ __Diabetes __High blood pressure __Cancer_____ __Other_____
Father: __Alive __Deceased/Age_____ __Diabetes __High blood pressure __Cancer_____ __Other_____

MEDICAL HISTORY ***(please circle)***

Diabetes. Hepatitis. Sleep. Apnea. Intestinal problems. Cancer. Gout. Rheumatoid arthritis. Kidney problems. HIV. Rashes. Lung problems.

Signature_____
Date_____