CONFIDENTIAL PATIENT INFORMATION

Patient Name _____ Date _____/_____/_____
(First, Middle, Last)

Gender M/F Date of Birth _____/_____/_____ Current Age _____ SSN# _____

_____
Address City/State/Zip

Phone (_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home Cell Other

Email _____ Best reached by EMAIL/PHONE/TEXT

AUTO ACCIDENT INFORMATION

Date and time of accident: _____ / _____ / 20____ Approx. Time _____:_____ ___AM ___PM
Were you ___ Driver ___ Front pass ___ Rear pass
Year, Make, and model of vehicle you were occupying _____
Did the police come to the accident site? YES/NO
Was a police report filed? YES/NO
Was a traffic violation issued? YES/NO
To whom was it issued? _____
Were there any witnesses? YES/NO
Number of people in your vehicle _____
Were you wearing a seatbelt? YES/NO
Did the airbags employ? YES/NO
Was the headrest above or below the base of your skull? ___ Above ___ At the Same Level ___Below
What did your vehicle impact? _____
Did any part of your body strike anything in the vehicle? YES/NO
Year, Make, and model of other vehicle(s) involved _____
Location and street name on which you were traveling _____
In which direction were you headed? __ N ___S ___E ___W
Approximate speed of your vehicle _____
Was impact of your vehicle at ___ Front ___ Rear ___ Right side ___ Left side ___ Other_____
During impact were you facing ___ Front ___ Right ___ Left
Did you see car coming/have a chance to brace yourself? YES/NO
Were you surprised/caught off guard by impact? YES/NO
What direction was the other vehicle traveling? ___ N ___ S ___ E ___ W
Were you hit ___ Head on ___ Rear ended ___ Other _____
Approximate speed of other vehicle _____
Please describe the accident in your own words _____
_____
_____
_____
_____
_____
_____

AFTER INJURY

Did the accident render you unconscious? YES/NO
Please describe how you felt immediately after the accident _____
_____
Have you gone to a hospital or seen any other doctor? YES/NO
Name of doctor _____
When did you go to the hospital? ___ Just after the accident ___ The next day ___ 2+ days ___Other _____
How did you get there? ___ Ambulance ___ Private transportation
Name of hospital and/or attending doctor _____
Was he/she a ___ MD ___ DO ___ DC ___ DDS
Describe the type of treatment you received _____
Were X(Rays taken? YES/NO
Was medication prescribed? YES/NO _____
Have you been able to work since the injury? YES/NO
Are your work activities restricted as a result of this injury? YES/NO
Describe your main pain symptoms_____
_____
_____
_____
Indicate the symptoms that are a result of this accident
___Dizziness ___Memory loss ___Headaches ___Blurred vision ___Buzzing in ear ___Ears ringing
___Difficulty Sleeping ___ Irritability ___ Fatigue ___ Tension ___ Neck pain ___Neck stiffness ___Jaw problems
___Arm/shoulder pain ___Numb hands/fingers ___Chest pain ___Shortness of breath ___Stomach upset
___Nausea ___Back pain ___Lower back pain ___Back stiffness ___Leg pain ___Numb feet/toes
Is your condition getting worse? ___ YES ___NO ___CONSTANT ___ COMES AND GOES

Level of comfort while performing the following activities

	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Lovemaking			
Walking			
Running			
Sports			
Working			
Lifting			
Bending			
Kneeling			
Reaching			
Pulling			

Have you retained an attorney? YES/NO
If yes, whom? _____
Attorney phone number/email: _____
_____

RECOVERY

How many hours are in your normal workday? _____
Please indicate your daily job duties and any activities which you are occasionally asked to perform
___ Standing ___ Sitting ___ Walking ___ Lifting ___ Driving ___ Twisting ___ Crawling ___ Bending
___ Operating equipment ___ Work with arms above head ___ Typing ___ Stooping
What positions can you work with a minimum physical effort and for how long? _____
Prior to injury were you capable of working on an equal basis with others your age? YES/NO N/A
Do you work with others who can help you with any heavy lifting? YES/NO N/A
Is there any light duty work you could request while in recovery? YES/NO N/A

Optimum Care Therapy & Dr. Senkosal Uy invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
Our policy requires payment in full for all services rendered at time of visit, unless arrangements have been made. If accounts are not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting the account.

I authorize the staff at Optimum Care Therapy & Dr. Senkosal Uy to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient (Parent/Legal Guardian) Name Patient (Parent/Legal Guardian) Signature Date

_____