MID-FLORIDA MEDICAL & CHIROPRACTIC CENTER

PATIENT REGISTRATION FORM

TODAYS DATE: _____/_____/_____ **DATE OF ACCIDENT:** _____/_____/_____

PATIENTS NAME: _____ ☐MR. ☐ MRS. ☐ MISS. ☐ MS.

IS THIS YOUR LEGAL NAME: ☐ YES ☐ NO **IF NOT WHAT IS YOUR LEGAL NAME:** _____

Height_____ **Weight**_____ **Right Handed** ☐ **Left Handed** ☐

MARITAL STATUS: (Please check one) SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOW ☐

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SEX:** MALE ☐ FEMALE ☐ SS# _____

STREET ADDRESS: _____ **CITY:** _____ **STATE/ZIP:** _____

CELL PHONE: (_____) _____ **HOME PHONE:** (_____) _____

WORK PHONE: (_____) _____ **E-Mail:** _____

IN CASE OF EMERGENCY: NAME OF LOCAL FRIEND OR RELATIVE

NAME: _____ **RELATIONSHIP:** _____ **PHONE #** (_____) _____

Are you: employed ☐ unemployed ☐ retired ☐ disabled ☐ student ☐

(If you are employed please complete the following:)

Where are you employed: _____What type of work do you do?_____

Do you: Work on a computer ☐ Have long sitting periods ☐ Have long standing periods ☐ Do a lot of bending ☐

Have you lost any days of work/school since the accident: Yes ☐ No ☐ (If Yes: how many days _____)

Due to the accident did you visit the hospital at anytime Yes ☐ No ☐ If yes, which hospital did you go to: _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ EFFECTIVE DATE: _____/_____/_____ EXPIRATION DATE _____/_____/_____

POLICY ID: _____ CLAIM # _____

INSURED'S NAME: _____ YOUR RELATIONSHIP TO INSURED: _____

ARE YOU A NAMED DRIVER ON THE INS. POLICY Yes☐ No ☐ DO YOU RESIDE WITH THE OWNER OF THE VEHICLE Yes☐ No ☐

Notes: _____

ATTORNEY INFORMATION

ATTORNEY'S NAME: _____ CASE WORKER: _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance not paid by my insurance company. I authorize Mid-Florida Medical & Chiropractic Center, Inc to release my medical records and appointment information to my insurance company and/or my attorney to help process my case and/or claim. I also authorize the release of my medical records from Mid-Florida Medical & Chiropractic Center to other physicians who treat me for my condition whilst under the care of Mid-Florida Medical & Chiropractic Center.

Patient's Signature: _____ Date: _____/_____/_____

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Patient Name: _____

Past Medical History

Do you have or have you been treated for any of the following: (check all that applies)

☐Asthma ☐Heart Disease ☐High Blood Pressure ☐Gastritis/Ulcers
☐Fibromyalgia ☐Stroke ☐Osteoporosis ☐Low/High thyroid
☐Liver Disease ☐Depression ☐Immunodeficiency ☐Kidney Disease
☐Diabetes ☐Seizures ☐Bleeding Disorder ☐Cataracts
☐Cancer (Type) _____ ☐Hepatitis (type_____) ☐Glaucoma
Please list any health problems (not listed above):_____

Hospitalization/Operations/Previous Accidents

Date	Reason/Procedure	Hospital

Current Medication (Please include any Vitamins or Herbal Medications)

Name	Dose	Frequency

Medication Allergies

List any Medication Allergies and the type of reaction: if none are known check her ☐

_____

Family History: Please check all that applies to your family members: M=mother / F=father)

☐Allergy ☐M☐F ☐High Blood Pressure ☐M☐F
☐Osteoporosis ☐M☐F ☐Kidney Disease ☐M☐F
☐Seizure ☐M☐F ☐Stroke ☐M☐F
☐Cancer ☐M☐F ☐Depression ☐M☐F
☐Diabetes ☐M☐F ☐Other ☐M☐F
☐Heart disease ☐M☐F

Social History

1. Do you presently Smoke Yes☐ No☐ If yes :: # Packs/day ____ # Years___
2. Have you ever smoked Yes☐ No☐ If yes :: #Packs/day ____ # Years___
3. Do you drink alcohol Yes☐ No☐ If Yes :: # Drinks _____ per week
4. Have you ever used any addictive substances? Yes☐ No☐ If Yes :: (Substance: _____)
5. **Do you have any children:** Yes☐ No☐ if yes please state # of children _____

FEMALE PATIENTS - PLEASE COMPLETE THE FOLLOWING:

Are you pregnant: Yes☐ No☐ (If yes) How Many Months _____ **Are you breast feeding?** Yes☐ No☐

When was your last menstrual period? _____ If Not Known please check here ☐

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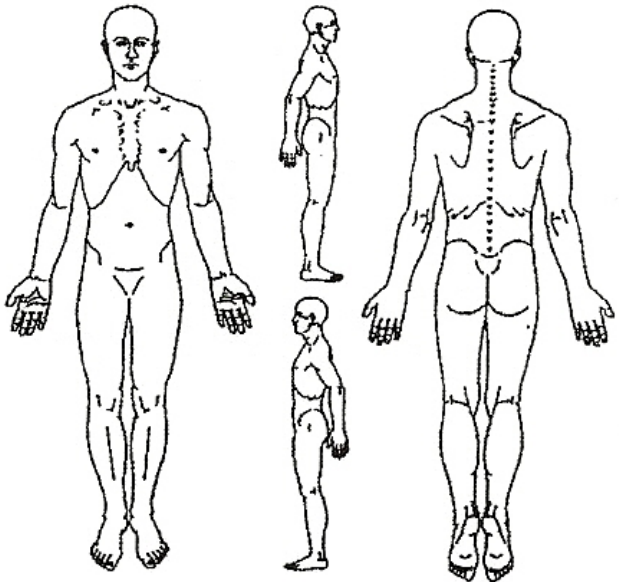
PAIN DIAGRAM

On the diagram below, please circle where you are experiencing pain or other symptoms at the present time:

Please indicate the areas circled with one or more of the following:

A = Aches **B** = Burning **N** = Numbness **P** = Pain **PN** = Pins & Needles **S** = Stabbing **O**= Other



I certify that I have read and understand all of the information requested of me concerning my medical history and health problems and that my answers are true and accurate to the best of my knowledge. I further certify that I do have the indicated health problem(s) and that I desire an appropriate medical examination, treatment and/or advice necessary.

Date: _____ **Print Name:** _____

Patient's Signature: _____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

❑ Car ❑ Station Wagon
❑ Van ❑ Pickup Truck
❑ Large Truck ❑ Bus
Other_____

2. Your position in vehicle

❑ Driver ❑ Front Passenger
❑ Left Rear Passenger
❑ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

❑ Stopped at intersection ❑ Stopped in traffic ❑ Stopped at light
❑ Making a right turn ❑ Making a left turn ❑ Parking
❑ Proceeding along ❑ Slowing down ❑ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
❑ Mild ❑ Moderate
❑ Totaled

5. Details of Accident

Visibility at time of accident
❑ Poor ❑ Fair ❑ Good

Who hit who/what?
❑ You hit other vehicle
❑ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
❑ Icy ❑ Wet ❑ Sandy ❑ Dark ❑ Clean and dry

Point of impact
❑ Head-On ❑ Left Front ❑ Right Front
❑ Read-End ❑ Left Rear ❑ Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes❑ ❑ No**
Were you braced for the impact? **Yes❑ ❑ No**
Did you have a seat belt on? **Yes❑ ❑ No**
Did you have a shoulder harness on? **Yes❑ ❑ No**

Does your vehicle have headrests? Yes❑ ❑ No
What was the position of your headrest at the time of the impact?
❑ Even with top of head ❑ Even with bottom of head ❑ Middle of neck
What was the direction of your head at the time of the impact?
❑ Facing straight forward ❑ Turned to the right ❑ Turned to the left

Did driver side air bags deploy? **Yes❑ ❑ No** Did passenger side airbags deploy? **Yes❑ ❑ No** Did side airbags deploy? **Yes❑ ❑ No**

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? **Yes❑ ❑ No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes❑ ❑ No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑ Mild ❑ Moderate ❑ Totaled
Did police show up at the scene? **Yes❑ ❑ No**
Was an accident report filled out? **Yes❑ ❑ No**

10. After the accident:

Check off your symptoms right after and a few days following:
❑ Headache ❑ Dizziness ❑ Mid back pain ❑ Cold hands
❑ Neck pain ❑ Nausea ❑ Low back pain ❑ Cold feet
❑ Neck stiffnes ❑ Confusion ❑ Nervousness ❑ Diarrhea
❑ Fainting ❑ Fatigue ❑ Loss of taste ❑ Depression
❑ Ringing in ears ❑ Tension ❑ Toe numbness ❑ Anxious
❑ Loss of smell ❑ Irritability ❑ Constipation ❑ Chest Pain
❑ Pain behind eyes ❑ Shortness of breath ❑ Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
❑ Home ❑ Work ❑ Hospital ER ❑ Private Doctor
How did you get there?
❑ Drove self ❑ Somebody else ❑ Ambulance ❑ Police
Were X-rays done? Yes ❑ ❑ No **Was lab work done?** Yes ❑ ❑ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed: _____
Treatments: ❑ Cervical Collar ❑ Ice **Other:** _____
Medications:_____
Follow-up instructions: _____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? **Yes❑ ❑ No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes❑ ❑ No**
Did treatments benefit you? **Yes❑ ❑ No**
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes❑ ❑ No**
Did treatments benefit you? **Yes❑ ❑ No**
Last visit date: ____/____/____

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ..... ___	Drying hair ..... ___	Brushing teeth ..... ___	Putting on shoes ..... ___	Preparing meals ..... ___	Taking out trash .. ___
Showering ..... ___	Combing hair ..... ___	Making bed ..... ___	Tying shoes ..... ___	Eating ..... ___	Doing laundry ..... ___
Washing hair .. ___	Washing face ..... ___	Putting on shirt .... ___	Putting on pants ..... ___	Cleaning dishes ..... ___	Going to toilet ..... ___

Difficulties with Physical Activities

Standing ..... ___	Walking ..... ___	Kneeling ..... ___	Bending back ..... ___	Twisting left ..... ___	Leaning back..... ___
Sitting ..... ___	Stooping ..... ___	Reaching ..... ___	Bending left ..... ___	Twisting right ..... ___	Leaning left ..... ___
Reclining ..... ___	Squatting ..... ___	Bending forward .. ___	Bending right ..... ___	Leaning forward ..... ___	Leaning right ..... ___
Standing for long periods ..... ___		Sitting for long periods..... ___		Walking for long periods..... ___	Kneeling for long periods ..... ___

Difficulties with Functional Activities

Carrying small objects ..... ___	Lifting weights off floor ..... ___	Pushing things while seated .... ___	Exercising upper body ..... ___
Carrying large objects ..... ___	Lifting weights off table ..... ___	Pushing things while standing .. ___	Exercising lower body ..... ___
Carrying brief case ..... ___	Climbing stairs ..... ___	Pulling things while seated ..... ___	Exercising arms ..... ___
Carrying large purse ..... ___	Climbing inclines ..... ___	Pulling things while standing .... ___	Exercising legs ..... ___

Difficulties with Social and Recreational Activities

Bowling ..... ___	Jogging ..... ___	Swimming ..... ___	Ice Skating ..... ___	Competitive Sports . ___	Dating ..... ___
Golfing ..... ___	Dancing ..... ___	Skiing ..... ___	Roller Skating ..... ___	Hobbies ..... ___	Dining out ..... ___

Difficulties with Travelling

Driving a motor vehicle ..... ___	Riding as a passenger in a motor vehicle ..... ___	Riding as a passenger on a train ..... ___
Driving for long periods of time ..... ___	Riding as a passenger on an airplane ..... ___	Riding as a passenger for long periods ..... ___

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating....____ Hearing....____ Listening....____ Speaking....____ Reading....____ Writing....____ Using a keyboard....____

Difficulties with the Senses

Seeing.....____ Hearing.....____ Sense of touch.....____ Sense of taste.....____ Sense of smell.....____

Difficulties with Hand Functions

Grasping.....____ Holding.....____ Pinching.....____ Percussive movements.....____ Sensory discrimination.....____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep.....____ Being able to participate in desired sexual activity.....____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- ❑ I have NOT had prior symptoms similar to my current complaints.
- ❑ My current complaints DID exist before, but have not been bothering me.
- ❑ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- ❑ My history HAS contributed to my current symptoms.
- ❑ My history HAS NOT contributed to my current symptoms.
- ❑ I 'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (**if applicable**) occured.....____ ❑ months ago / ❑ years ago **Or on** Date: ____/____/____

Write in below any other Prior Symptom History, not covered above: