Welcome

1 About you

Today's Date: ____/____/________ File # ____________

Patient Name: ____

Last First MI

What you prefer to be Called ____________ ❑ Male ❑ Female

Birthdate: ______________ Age ______ SS# ____________

Mailing Address: ____

____

City State Zip

Home Phone #: ____

Work Phone #: ______________________ Ext__________

Cell Phone #: ____

Email Address: ____

Employer: ______________________________ How long? ____

Employers Address: ____

____

____

City State Zip

Occupation: ____

Status: minor Single Married Divorced Separated Widowed

Spouses Name: ____

Do you have kids? Yes No How many ________

2 Insurance Info

Co. Name: ______________________

Address: ______________________

Phone#: ______________________

Insureds SS#: ______________________

Group# (Plan, Local or Policy#)

Insured's Name: ______________________

Relation: ______________________

Date of Birth ____/____/____

Insured's Employer: ______________________

____

Please inform front desk of 2nd. Insurance source

3 REASON FOR VISIT

The reason for this visit is a result of: (please circle): work sport auto trauma or chronic

(Explain what happened): ____

____

____

Please describe the pain & its location : ____

____

When did this condition begin? ____/____/____

Is this condition getting worse?

Yes No Constant Comes & goes

Is this condition interfering with your: (Please circle) work sleep or daily routine

If so please explain : ____

____

Have you been treated by a Physician for this condition ? Yes No

If so Where ? ____

4 IN EVENT OF EMERGENCY

Who should we contact? : ______________________________

Relation : ______________________________

Home phone# : ______________ Work phone#: ______________

Who is your Medical Doctor? ______________ phone#: ______________

5 HEALTH HISTORY

Are you taking any of the following medications?

❏ Nerve pills ❏ Pain killers (including aspirin) ❏ Muscle relaxers ❏ Stimulants ❏ Blood thinners ❏ Tranquilizers ❏ Insulin

❏ Others ______________________________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Dizziness	Y N Jaw Problems	Y N Leg pain
Y N Congenital Heart Defect	Y N Mitral valve Prolapse	Y N Artificial Valves	Y N Difficulty sleeping	Y N Irritability	Y N Ears ringing
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N Nausea	Y N Back pain	Y N Stomach upset
Y N HIV+/ Aids	Y N Shingles	Y N Cancer	Y N Arm/Shoulder pain	Y N Headaches	Y N Numb Feet/Toes
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia	Y N Fatigue	Y N Numb Hands/Fingers	Y N Neck pain
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Blurred vision	Y N Lower back pain	Y N Memory loss
Y N Severe Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis	Y N Back stiffness	Y N Tension	Y N Arthritis
Y N Fainting/Seizures/Epilepsy	Y N Sinus problems	Y N Asthma	Y N Shortness of breath	Y N Chest pain	Y N Artificial Bones / Joints
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy	Y N Neck stiff	Y N Buzzing in ear	Y N Lower Back Problems

Please list any other serious medical condition(s) you have or ever had: ______________

Please list anything that you may be allergic to: ______________

List previous surgeries / treatments with dates: ______________

____

____

List any past serious accidents with dates: ______________

Family Health History: ______________

____

Do you: Take supplements or vitamins? ❏ Yes ❏ No / Exercise ❏ Yes ❏ No

Are you on a special diet ❏ Yes ❏ No / Since ____/____/____

Do you Smoke? ❏ Yes ❏ No / How much __________ How long _____

Are you wearing Heel Lifts ❏ Sole Lifts ❏ Inner Soles ❏ Arch Supports

For women:

Are you taking Birth Control? ❏ Yes ❏ No

Are you pregnant? ❏ No ❏ Yes / How Long?

Nursing? ❏ Yes ❏ No

■ I agree to pay for services rendered to the above mentioned patient as the charges are incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. The injuries / illness sustained and the pain and suffering I have are real and I have not either imagined or exaggerated the extent and nature of my pain and suffering or illness.

■ I am of sound mind, and to the best of my knowledge all the information I have presented is true. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

Signature ______________________________

PAIN CHART

About you

PATIENT NAME: ______________________ FILE # __________

WHAT IS YOUR CURRENT WEIGHT: _____ LBS, AND HEIGHT _____FT_____IN.

PLEASE DESCRIBE YOUR CONDITION: ______________________

____

____

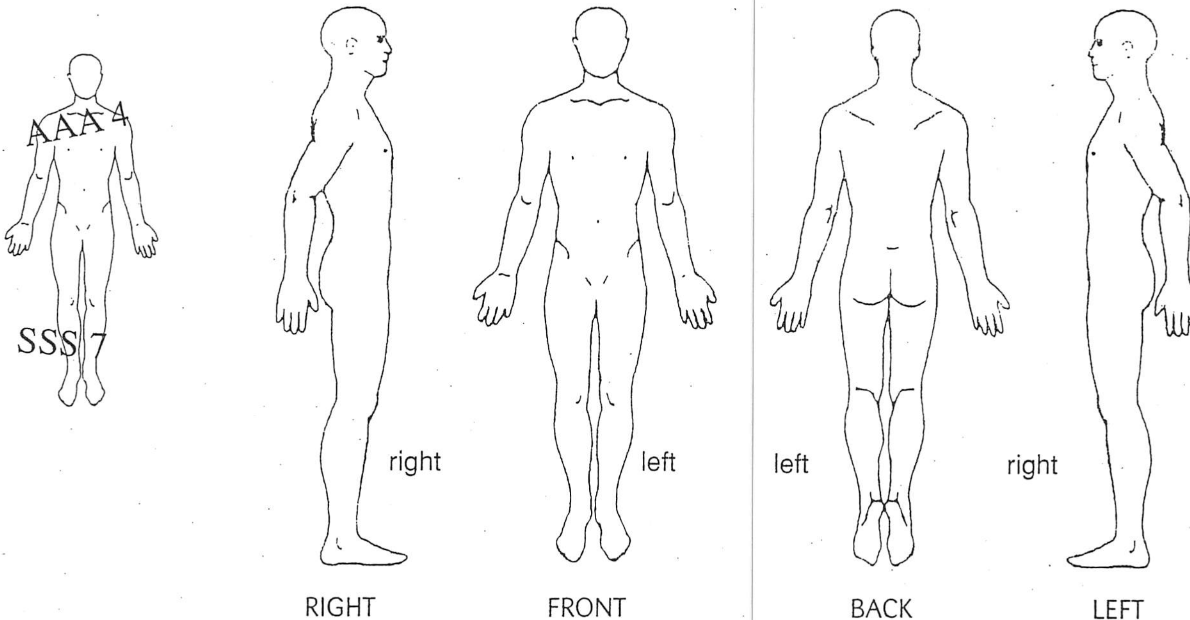
____

SIGNATURE ______________________ DATE __________

Show us where it hurts

PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT AS SHOWN IN THE EXAMPLE BELOW. MARK ALL AREAS WITH THE APPROPRIATE SYMBOLS AND INDICATE THE DEGREE OF PAIN USING A SCALE: FROM 1 (DISCOMFORT) TO 10 (EXTREME PAIN).

DESCRIPTION	NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
SYMBOL	NNN	PPPP	BBBB	AAAA	SSSS



Doctors Notes

____

____

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____

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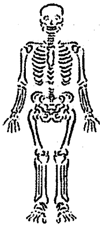
PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET



REHAB DIAGNOSTIC SERVICES

859 Ralph David Abernathy Blvd.
Atlanta, GA 30310
Phone (404) 756-6388 Fax (404) 756-6390

PERSONAL INJURY FORM

Patient Name ______________________________ Date ______________

PLEASE ANSWER OR MARK THE APPROPORIATE CIRCLES COMPLETELY TO EACH QUESTIONS

About your ACCIDENT,

Date Of Accident ______________

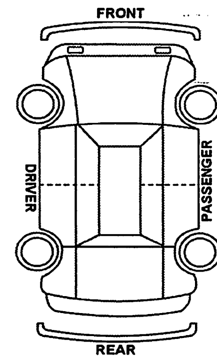
I am a _____ year old ○M / ○F who was involved in a motor vehicle accident

I was the: ○Driver ○Passenger ○Pedestrian

** *If passenger*: ○Front seat or Rear seat on ○Right ○Middle ○Left

The vehicle was struck from: ○Front ○Rear ○Driver side ○Passenger side

On the diagram, please mark the area that the vehicle was struck



Were you wearing a seatbelt? ○Yes ○No

Did airbags deploy? ○Yes ○No

Were you unconscious? ○Yes ○No

Did you suffer any abrasions or contusions? ○Yes ○No

Broken bones? ○Yes ○No

Did you go to hospital or E.R.? ○Yes ○No

If yes, via Ambulance? ○Yes ○Other __________

Were X-rays or other images taken? ○Yes ○No

Are you taking any pain medications? ○Yes ○No

About your PAIN,

Where are you hurting?

○ Neck ○ Mid back ○ Low back ○ Rt / Lt Arm ○ Rt / Lt Hand ○ Rt / Lt Shoulder
○ Rt / Lt Hip ○ Rt / Lt Knee ○ Rt / Lt Leg ○ Rt / Lt Ankle ○ Chest ○ Headaches

How would you rate your pain? (0 = no pain at all, 10 = the worst pain ever)

0 1 2 3 4 5 6 7 8 9 10

How often do you have the pain? ○Rarely ○On and off ○Frequent

How would you describe your pain?

○ Dull Ache ○ Stiffness ○ Tension ○ Sharp ○ Burning ○ Weakness
○ Numbness ○ Tingling ○ Throbbing ○ Stabbing ○ Other ______________

What relieves your pain?

○ Nothing ○ Rest ○ Brace ○ Sitting ○ Lying
○ Walking ○ Hot Pack ○ Cold Pack ○ Medication ○ Other ______________

What makes your pain worse?

○ Lifting ○ Pushing ○ Pulling ○ Sitting ○ Driving ○ Cough/Sneeze
○ Bending ○ Walking ○ Running ○ Standing ○ Lying ○ Other ______

Are you currently working? ○Yes ○No Date last worked ______________

Have you missed any time from work because of pain? ○Yes ○No Dates ______________