Patient Name: _____ MVA Clinical Intake Form

PREMIER FAMILY PHYSICIANS

General Information

To help us provide the best care possible, please thoroughly complete and sign the following pages. This information is confidential and will be kept as a part of your permanent record. None of this information will be shared outside this office, unless it is authorized by the patient.

Patient Name: _____ (Last) _____ (First) ____/____/____ Date of Birth

_____ SS# _____ Age Sex: Male/ Female

Address: _____

_____ City _____ State _____ Zip Code

_____ Home Phone _____ Work Phone _____ Cell Phone _____ E-mail

_____ Occupation _____ Employer

Primary Care Physician: _____ Name _____ Location _____ Phone#

Emergency Contact : _____ Name _____ Relationship _____ Phone #

Are you a Medicare patient? Yes / No _____ Medicare #

****Female Only**

Are you pregnant? Yes / No ____/____/____ Due Date _____ OBGYN name

Consent to Examination

Proper evaluation of your current condition includes the appropriate history and physical examination. By signing below you attest that the information above is true and correct and also, you *give permission for the doctor and the staff to conduct necessary evaluation*, including any physical testing required.

_____ Signature of Patient/Guardian(if patient is a minor) ____/____/____ Date

_____ Printed name of Patient/ Guardian(if patient is a minor)

Patient Name: _____ MVA Clinical Intake Form

PREMIER FAMILY PHYSICIANS

Personal Health History

An accurate clinical picture of your current state of health is needed. Please check the frequency of all conditions you are currently experiencing or that have changed since the accident.

Key: O = Occasional F = Frequent C = Constant

General
O F C
[ ] [ ] [ ] Dizziness
[ ] [ ] [ ] Fainting
[ ] [ ] [ ] Fatigue
[ ] [ ] [ ] Fever
[ ] [ ] [ ] Headache
[ ] [ ] [ ] Neuralgia
[ ] [ ] [ ] Night Sweats
[ ] [ ] [ ] Poor Posture
[ ] [ ] [ ] Sciatica
[ ] [ ] [ ] Sweats
[ ] [ ] [ ] Involuntary Shaking
[ ] [ ] [ ] Unexplained weight loss
[ ] [ ] [ ] Fibromyalgia
[ ] [ ] [ ] Poor diet

Gastrointestinal
O F C
[ ] [ ] [ ] Belching/Gas
[ ] [ ] [ ] Bloating
[ ] [ ] [ ] Colitis
[ ] [ ] [ ] Constipation
[ ] [ ] [ ] Diarrhea
[ ] [ ] [ ] Poor appetite
[ ] [ ] [ ] Nausea
[ ] [ ] [ ] Vomiting

Muscle/Joint
O F C
[ ] [ ] [ ] Arthritis
[ ] [ ] [ ] Muscle weakness
[ ] [ ] [ ] Neck stiffness
[ ] [ ] [ ] Low back pain
[ ] [ ] [ ] Back stiffness
[ ] [ ] [ ] Mid back pain
[ ] [ ] [ ] Joint locking
[ ] [ ] [ ] Painful clicking
[ ] [ ] [ ] Muscle spasm
[ ] [ ] [ ] Neck pain
[ ] [ ] [ ] Muscle tremors
[ ] [ ] [ ] Bone fracture

Pain/Numbness
O F C
[ ] [ ] [ ] Shoulders
[ ] [ ] [ ] Arms
[ ] [ ] [ ] Elbows
[ ] [ ] [ ] Hands
[ ] [ ] [ ] Hips
[ ] [ ] [ ] Legs
[ ] [ ] [ ] Knees
[ ] [ ] [ ] Ankles
[ ] [ ] [ ] Feet
[ ] [ ] [ ] Heels
[ ] [ ] [ ] Back
[ ] [ ] [ ] Groin

Genitourinary
O F C
[ ] [ ] [ ] Blood in urine
[ ] [ ] [ ] Frequent urination
[ ] [ ] [ ] Incontinence
[ ] [ ] [ ] Kidney infections
[ ] [ ] [ ] Kidney stones
[ ] [ ] [ ] Painful urination
[ ] [ ] [ ] Difficulty urinating

Respiratory
O F C
[ ] [ ] [ ] Chest pain
[ ] [ ] [ ] Chronic cough
[ ] [ ] [ ] Difficulty breathing
[ ] [ ] [ ] Wheezing

Ear, Eye, Nose, Throat
O F C
[ ] [ ] [ ] Asthma
[ ] [ ] [ ] Colds
[ ] [ ] [ ] Ear ache
[ ] [ ] [ ] Ear discharge
[ ] [ ] [ ] Ear infections
[ ] [ ] [ ] Enlarged glands
[ ] [ ] [ ] Eye pain
[ ] [ ] [ ] Hoarseness
[ ] [ ] [ ] Hearing Loss
[ ] [ ] [ ] Sinus Infections

Cardiovascular
O F C
[ ] [ ] [ ] Ankle swelling
[ ] [ ] [ ] Heart attack
[ ] [ ] [ ] High blood pressure
[ ] [ ] [ ] Low blood pressure
[ ] [ ] [ ] Poor circulation
[ ] [ ] [ ] Rapid heartbeat
[ ] [ ] [ ] Slow heartbeat

Conditions
Have/had
[ ] Addiction
[ ] Anemia
[ ] Back surgery
[ ] Cancer
[ ] Diabetes
[ ] Eating disorder
[ ] Eczema
[ ] Epilepsy
[ ] Gout
[ ] Heart disease
[ ] HIV/AIDS
[ ] Multiple Sclerosis
[ ] Pacemaker
[ ] Stroke
[ ] STD
[ ] Hepatitis

Any other current health issues not covered above: _____

_____

Please list any medications/drugs you are currently taking: _____

_____

_____ / / _____

Signature of Patient/Guardian(if patient is a minor) Date

_____

Printed name of Patient/ Guardian(if patient is a minor)

Patient Name: _____ MVA Clinical Intake Form

PREMIER FAMILY PHYSICIANS

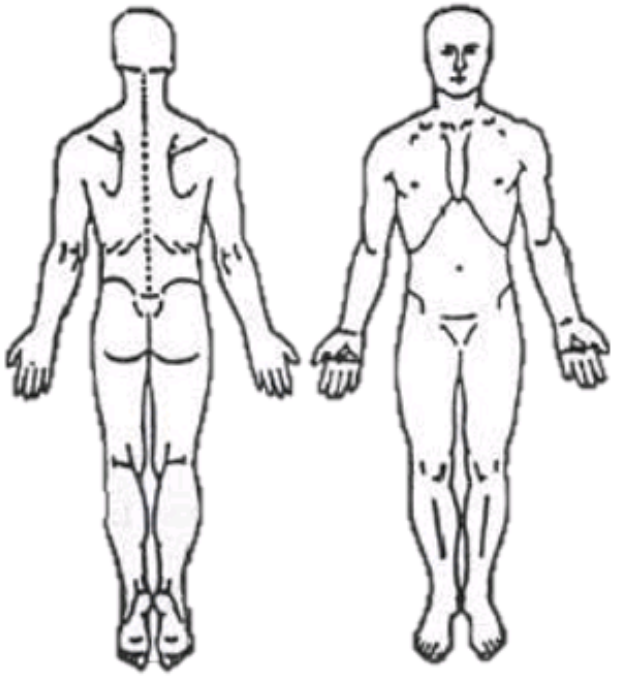
Primary Complaints

What is/are your main complaint(s) related to you motor vehicle accident? (check those that apply)

[ ] Dizziness/Vertigo	[ ] Elbow Pain	[ ] Limited Range of Motion	[ ] Pins and Needles
[ ] Headaches	[ ] Digestive Problems	[ ] Fatigue	[ ] Vision Disturbances
[ ] Sciatica	[ ] Asthma	[ ] Hip Pain	[ ] Clicking and Grinding
[ ] Low Back Pain	[ ] Low Back Stiffness	[ ] Chest Pain	[ ] Ear Discomfort/Pain
[ ] Mid/Upper Back Pain	[ ] Shoulder Pain	[ ] Shoulder Stiffness	[ ] Tension
[ ] Neck Pain	[ ] Neck Stiffness	[ ] Depression	[ ] Numbness
[ ] Wrist/Hand Pain	[ ] Knee Pain	[ ] Nerve Pain	[ ] Ankle/Foot Pain
[ ] Difficulty Breathing	[ ] Jaw Pain/Stiffness	[ ] Difficulty Sleeping	[ ] Weakness

Other (not covered above) _____

Please indicate area(s) of pain below



When did the condition begin? _____

What do you think caused it? _____

Is this condition interfering with your:

work / sleep / daily routine / other: _____

Is this condition a result of a motor vehicle accident?

Yes / No

What positions/ activities make it feel worse? _____

What positions/ activities make it feel better? _____

What have you tried that has *not* worked to alleviate your condition(s)? _____

Have you received treatment for *this* condition by other doctors/therapists? Yes / No

If so, by whom and when? _____

Have you had similar conditions in the past? Yes / No How long ago? _____

Since it began, is this condition generally getting: worse / better / stays the same

_____ / / _____

Signature of Patient/Guardian(if patient is a minor) Date

_____

Printed name of Patient/ Guardian(if patient is a minor)