CENTRAL FLORIDA INJURY
Rehabilitation
Phone: (407) 381-5100 Fax: (407) 275-9395

WELCOME TO OUR TREATMENT CENTER!

To help us provide you the best possible care, please fill out the following information.

Demographic Information:

Name: _____ DOB: _____ Gender: M or F

SSN: _____ How long have you lived in Florida? _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

Employer: _____

Address: _____ City, State, Zip: _____

Accident Information:

Type of Accident (circle one): Auto Accident Slip & Fall

Date of Accident: _____ Time of Accident: _____ AM PM

Location of Accident: _____

If Auto Accident: Were you the (circle one): Driver Passenger Seatbelt fastened? Yes ☐ No ☐

If Accident was a slip & fall, please describe: _____

_____

Auto Insurance:

Insurance Company Name: _____

Name of Insured: _____ Relationship to Patient: _____

Policy #: _____ Claim #: _____

Attorney Information:

Name of Firm: _____

Attorney's Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Medical Checklist:

Please list following:

Allergies to Medications: _____

Current Medications: _____

Previous Surgeries: _____

All medical conditions: _____

Previous orthopedic treatment: _____

Previous chiropractic treatment: _____

Primary Care Physician: _____ Phone: _____

When did you have your last medical check-up? _____

Do you…

Smoke tobacco? Yes ☐ No ☐ Drink alcohol excessively? Yes ☐ No ☐ Do illicit drugs? Yes ☐ No ☐

Have a family history of Diabetes or High Blood Pressure? Yes ☐ No ☐ If so, who? _____

Is it possible you could be pregnant? Yes ☐ No ☐

Additional Accident Information:

Describe the accident: _____

_____

_____

If Auto Accident: Were you the (circle one): Driver Passenger Seatbelt fastened? Yes ☐ No ☐

Was an accident report filled out? Yes ☐ No ☐

Make/model of vehicle you were occupying: _____

If you were the passenger, where were you sitting in the vehicle? _____

Was another vehicle involved? Yes ☐ No ☐ Make/model of other vehicle: _____

What speed was your vehicle traveling? _____ Were you accelerating? Yes ☐ No ☐

What was your vehicle doing immediately prior to impact? (i.e. changing lanes, stopped at a stop sign, turning at an intersection, etc.) _____

What was your vehicle's point of impact? (i.e. front/rear bumper, front fender, etc.) _____

What was the amount of damage to your vehicle? _____

Additional Accident Information (cont'd):

Does your car have airbags? Yes ☐ No ☐ Did the airbags deploy? Yes ☐ No ☐

Did any part of your body strike any part of your vehicle due to the impact? Yes ☐ No ☐

Describe your injuries: _____

_____

_____

Did you receive emergency care at the scene? Yes ☐ No ☐ If no, did you go to the hospital? Yes ☐ No ☐

If so, how did you get there? _____

Name of Hospital: _____

Did you have…

X-rays? Yes ☐ No ☐ CT scans? Yes ☐ No ☐ MRIs? Yes ☐ No ☐

Any other treatment? Yes ☐ No ☐ If yes, please explain: _____

Were you given any medications? Yes ☐ No ☐ If yes, which ones: _____

Did you miss any work? Yes ☐ No ☐ If yes, give dates: _____

If you did not go to the hospital, where did you go immediately after the accident? _____

Who referred you to our office?/ How did you hear of our office? _____

_____

May we thank them for referring you? Y N May we send a copy of your initial evaluation? Y N

I HEREBY STATE THAT THE INFORMATION PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE.

Printed Name: _____ Date: _____

Signature: _____