



**CENTRAL FLORIDA INJURY & REHABILITATION CENTER, INC.**

5555 E. Michigan St., Suite 102, Orlando, FL 32822

Phone: (407) 275-9334 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? \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

**Additional Accident Information (cont'd):**

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: \_\_\_\_\_