

# Thank You for choosing Goldson Spine Rehab Center!



**Please fill this form out completely and to the best of your ability.**

**CONFIDENTIAL PATIENT INFORMATION**

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M/F Marital Status: S M D # of Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

Have you had any prior injuries? Y/N if yes, please explain:

Have you had any operations? Y/N if yes, please explain:

Do you have any serious illness? Y/N if yes, please explain:

Are you pregnant? Y/N

Other doctors seen for this condition: \_\_\_\_\_

Are you taking any medications/drugs at this time? Y/N if yes, please list them:

***Please check off all that apply:***

Habits

- Smoking Packs/Day: \_\_\_\_\_
- Drinking Cups/Day: \_\_\_\_\_
- Coffee Cups/Day: \_\_\_\_\_

Exercise

- None
- Moderate *Type of exercise:* \_\_\_\_\_
- Daily \_\_\_\_\_

Family History

	<i>Diabetes</i>	<i>Heart</i>	<i>Kidney</i>	<i>Cancer</i>	<i>Back</i>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister, # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which hand do you use? ( ) Right or ( ) Left    Change in urinary function? ( ) Yes or ( ) No

Are you insured? ( ) Yes or ( ) No    Insurance Company: \_\_\_\_\_

Policy # \_\_\_\_\_ ***PAYMENT IS EXPECTED AT TIME OF VISIT!***

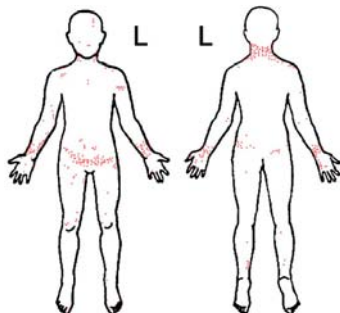
**If this is auto accident related, please list the following information and fill out opposite side of this form:**

Claim # \_\_\_\_\_ Adjuster \_\_\_\_\_ Telephone \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Social Security # \_\_\_\_\_

Guardian or Spouse's Signature authorizing care (if applicable) \_\_\_\_\_

Information taken by (if applicable) \_\_\_\_\_ Date \_\_\_\_\_



*\*Please shade in the area where you are feeling discomfort.*

- Have you had any of the following diseases? (check all that apply)*
- ( ) Appendicitis    ( ) Anemia    ( ) Heart Disease    ( ) Pneumonia
  - ( ) Measles    ( ) Goiter    ( ) Rheumatic Fever    ( ) Mumps    ( ) Eczema
  - ( ) Influenza    ( ) Polio    ( ) Chicken Pox    ( ) Pleurisy
  - ( ) Tuberculosis    ( ) Diabetes    ( ) Alcoholism    ( ) Whooping Cough
  - ( ) Cancer    ( ) Venereal Disease    ( ) Arthritis    ( ) Lumbago

Date of Accident: \_\_\_\_\_

### 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.

<b>1. Your vehicle type</b> <input type="checkbox"/> Car <input type="checkbox"/> Station Wagon <input type="checkbox"/> Van <input type="checkbox"/> Pickup Truck <input type="checkbox"/> Large Truck <input type="checkbox"/> Bus Other _____	<b>2. Your position in vehicle</b> <input type="checkbox"/> Driver <input type="checkbox"/> Front Passenger <input type="checkbox"/> Left Rear Passenger <input type="checkbox"/> Right Rear Passenger Other _____	<b>3. What was your vehicle doing at the time of the accident?</b> <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Stopped at light <input type="checkbox"/> Making a right turn <input type="checkbox"/> Making a left turn <input type="checkbox"/> Parking <input type="checkbox"/> Proceeding along <input type="checkbox"/> Slowing down <input type="checkbox"/> Accelerating Other _____
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<b>4. Time/Speed/Damage</b> Time of accident _____ Your vehicle's speed: _____ mph Their vehicle's speed: _____ mph <b>Damage to your vehicle</b> <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled	<b>5. Details of Accident</b> <b>Visibility at time of accident</b> <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <b>Who hit who/what?</b> <input type="checkbox"/> You hit other vehicle <input type="checkbox"/> Other vehicle hit you <b>You hit...(object)</b> _____	<b>6. Road conditions</b> <b>Road conditions at time of accident</b> <input type="checkbox"/> Icy <input type="checkbox"/> Wet <input type="checkbox"/> Sandy <input type="checkbox"/> Dark <input type="checkbox"/> Clean and dry <b>Point of impact</b> <input type="checkbox"/> Head-On <input type="checkbox"/> Left Front <input type="checkbox"/> Right Front <input type="checkbox"/> Rear-End <input type="checkbox"/> Left Rear <input type="checkbox"/> Right Rear
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<b>7. Body Position, etc.</b> Did you see the accident coming?    Yes <input type="checkbox"/> No <input type="checkbox"/> Were you braced for the impact?    Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a seat belt on?    Yes <input type="checkbox"/> No <input type="checkbox"/> Did you have a shoulder harness on?    Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Does your vehicle have headrests? Yes <input type="checkbox"/> No <input type="checkbox"/></b> <b>What was the position of your headrest at the time of the impact?</b> <input type="checkbox"/> Even with top of head <input type="checkbox"/> Even with bottom of head <input type="checkbox"/> Middle of neck <b>What was the direction of your head at the time of the impact?</b> <input type="checkbox"/> Facing straight forward <input type="checkbox"/> Turned to the right <input type="checkbox"/> Turned to the left
Did driver side air bags deploy? Yes <input type="checkbox"/> No <input type="checkbox"/> Did passenger side airbags deploy? Yes <input type="checkbox"/> No <input type="checkbox"/> Did side airbags deploy? Yes <input type="checkbox"/> No <input type="checkbox"/>	

**8. Did you lose time from work?**  
 in the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

<b>9. During the accident:</b> Did your body strike the inside of your vehicle?    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, describe: _____ Did you lose consciousness during the injury?    Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, for how long? _____ Your vehicle's estimated damage? _____ <b>Damage to their vehicle:</b> <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Totaled Did police show up at the scene?    Yes <input type="checkbox"/> No <input type="checkbox"/> Was an accident report filled out?    Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>10. After the accident:</b> <b>Check off your symptoms right after and a few days following:</b> <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Mid back pain <input type="checkbox"/> Cold hands <input type="checkbox"/> Neck pain <input type="checkbox"/> Nausea <input type="checkbox"/> Low back pain <input type="checkbox"/> Cold feet <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Confusion <input type="checkbox"/> Nervousness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of taste <input type="checkbox"/> Depression <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Tension <input type="checkbox"/> Toe numbness <input type="checkbox"/> Anxious <input type="checkbox"/> Loss of smell <input type="checkbox"/> Irritability <input type="checkbox"/> Constipation <input type="checkbox"/> Chest Pain <input type="checkbox"/> Pain behind eyes <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleeping problems Others: _____
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<b>11. Emergency Room?</b> <b>Where did you go after the accident?</b> <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Hospital ER <input type="checkbox"/> Private Doctor <b>How did you get there?</b> <input type="checkbox"/> Drove self <input type="checkbox"/> Somebody else <input type="checkbox"/> Ambulance <input type="checkbox"/> Police <b>Were X-rays done? Yes <input type="checkbox"/> No <input type="checkbox"/></b> <b>Was lab work done? Yes <input type="checkbox"/> No <input type="checkbox"/></b> Body parts X-rayed? _____ What lab work? _____ The X-rays revealed: _____ <b>Treatments:</b> <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Ice <b>Other:</b> _____ Medications: _____ Follow-up instructions: _____	<b>12. Treatment History:</b> <b>Fill in any other doctor(s) seen prior to your first visit to this office.</b> 1. Dr. _____ First visit date: ____/____/____ Specialty: _____ X-rays done?    Yes <input type="checkbox"/> No <input type="checkbox"/> Types of treatments received: _____ How many treatments received? ____ Currently treating? Yes <input type="checkbox"/> No <input type="checkbox"/> Did treatments benefit you?    Yes <input type="checkbox"/> No <input type="checkbox"/> Last visit date: ____/____/____ 2. Dr. _____ First visit date: ____/____/____ Types of treatments received: _____ How many treatments received? ____ Currently treating: Yes <input type="checkbox"/> No <input type="checkbox"/> Did treatments benefit you?    Yes <input type="checkbox"/> No <input type="checkbox"/> Last visit date: ____/____/____
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