

Buckeye Health & Rehabilitation
INITIAL AUTO ACCIDENT/PERSONAL INJURY HISTORY QUESTIONNAIRE

Name: _____ DOB: _____ Chart/File#: _____

Did you report this Accident to your Insurance Company?: Yes No

Your Auto Insurance Company: _____ Phone#: _____

Your Auto Insurance Billing Address: _____ Fax#: _____

_____ Claim#: _____

Do you have "in excess of" policy? (This is a coordination of benefits with your Health Insurance): Yes No

Date of Accident: _____ Were you the? Driver Front or Back Passenger Were you wearing a seatbelt? Yes No

Were the police notified?: Yes No Were you at fault?: Yes No If no, who was? _____

Their Auto Insurance Company: _____ Phone#: _____

Were there any witnesses?: Yes No If yes, please list: _____

What areas of the body did you injure during the accident (Please list the most severely injured to least severely injured by number.) (Example: #1. Neck pain with pain and numbness into the right arm down to my first two fingers, #2. Right Shoulder pain, #3. Right Elbow Pain, #4. Mid Back pain): _____

In your own words, please describe the accident. (Start below and continue explaining everything in great detail on the back of this form):

Has the pain worsened or improved since the injury? (Please Explain): _____

Have you been treated by another doctor for this injury.: Yes No If yes, where & by whom: _____

Have you contacted an Attorney?: Yes No If yes, which Attorney & Phone#: _____

Are you having any other active health issues not related to this injury and what treatments? (Examples: Hypertension - medication, Diabetes - insulin injections, etc.):

Do you have inactive health issues, year, & what treatments? (Examples: Gout 2006 - medication, Cancer 2003 - remission/chemo, etc.): _____

Past Injures & Surgeries, Year? (Examples: Broken Leg 2004, Hernia Repair 2005, etc.): _____

Current Medications, Dosage, and Frequency? (Albuterol 200mg - 2x a day, Over the Counter Ibuprofen 400mg - 3 times a day): _____

Allergies (Example: Bees, etc): _____

Family Medical History (Example: Father Diseased - Cancer, Mother Alive - Heart Transplant, Brother Alive - Diabetic): _____

Social History (Example: Social Drinker 2 Beers - 2x a week, Smoker - 2 packs a day, I like to fish, watch movies, play with my 3 children): _____

Occupational History (Example: Hate my job, 6 days/week past 7 years at Caito Foods w/ repetitive motions, lost 4 days of work due to this problem): _____

Other Conditions: Please circle and clarify on the line below any of the following you have had in the past: (Aids, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Bleeding Disorders, Breast Lump, Bronchitis, Bulimia, Cancer, Cataracts, Chemical Dependency, Chicken Pox, Diabetes, Emphysema, Epilepsy, Glaucoma, Goiter, Gonorrhea, Gout, Heart Disease, Hepatitis, Hernia, Herpes, High Cholesterol, HIV Positive, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, Pace Maker, Pneumonia, Polio, Prostate Problems, Psychiatric Care, Rheumatic Fever, Scarlet Fever, Stroke, Suicide Attempt, Thyroid Problems, Tonsillitis, Tuberculosis, Typhoid Fever, Ulcers, Vaginal Infections, Venereal Disease, etc.):

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature (Guardian's Signature if Minor): _____ Date: _____

Witness' Signature: _____ Date: _____