

MD PHYSICIANS REHABILITATION CENTERS

2639 W. State Road 434
Longwood, FL 32779
Phone: 407-622-6590 Fax: 407-622-6592

WELCOME TO OUR TREATMENT CENTER

To help us provide you with the best possible care, please provide the following information:

Today's Date: _____

Date of Accident: _____

Demographic Information:

Name: _____ DOB: _____ Gender: M or F

SSN: _____ Marital Status: _____

Address: _____ Apt. Number: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____

Address _____

City: _____ State: _____ Zip: _____

Email: _____

Emergency Contact:

Name: _____ Phone: _____

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: _____

Social History: (Circle all that apply to you)

Caffeine use: Always Occasional Never
Drink Alcohol: Always Occasional Never
Exercise: Always Occasional Never
Chew Tobacco: Always Occasional Never
Cigarettes: <1 pack/day >1 pack/day Never

Other: _____

Medical Conditions: (Check all that apply to you)

Arthritis Cancer Diabetes Heart Disease
 Hypertension Psychiatric Illness Skin Disorder Stroke
 HIV AIDS Hepatitis A B C MRSA

Other: _____

Surgeries: (Check all that apply to you)

Appendectomy Knee Cervical Spine Hysterectomy
 Joint Replacement Prostate Thoracic Spine Gall Bladder
 Brain Shoulder Lumbar Spine Uro – Genital
 Carpal Tunnel Hernia Cardiovascular procedure Gastro-Intestinal

Other: _____

Allergies: (Check all that apply to you)

Eggs Fish and Shellfish Milk or Lactose Peanuts
 Soy Sulfites Wheat/Glutens Latex

Other: _____

Is it possible you could be pregnant? Yes or No

Did you receive emergency care at the scene? Yes or No.

If no, did you go to the hospital? Yes or No

Name of Hospital: _____

Did you have:

X-rays: Yes or No CT Scans: Yes or No MRIs: Yes or No

Have you been treated at any other facility for this accident? Yes or No

If yes, please explain: _____

Where you given any medications? Yes or No. If yes, which ones: _____

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

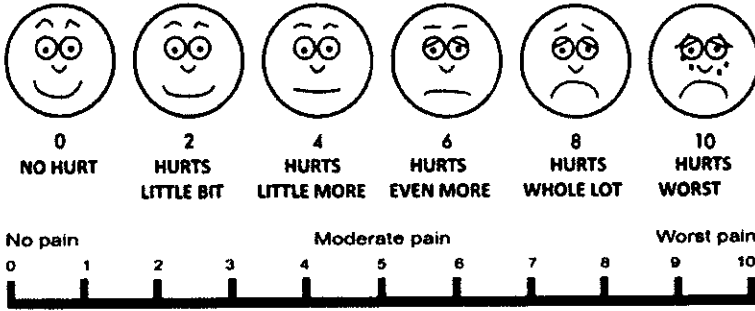
I HEREBY STATE THAT THE INFORMATION PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE.

Patient/Guardian Signature: _____ **Date:** _____

Printed Name: _____

Patient Name: _____

What is your pain level today?



Have you experienced any of the following since your injury? (Check all that apply to you)

- Dizziness Blurred Vision Loss of Memory
 Difficulty Breathing Confusion Bleeding

Mark Yes (Y) or No (N) on each line:

- Cardiac Pacemaker Aneurysm Clip(s)
 Cardiac Defibrillator Screw
 Neurostimulator Stent, filter or intravascular coil
 Hearing Aid Any type of surgical clips or staples
 Artificial Limb or Joint Any type of foreign body, shrapnel or bullet
 Wire Mesh Stent, filter or intravascular coil
 Any type of implant? Describe: _____
 Other (Please Describe): _____

Please list ALL current medications:

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

Patient/Guardian Signature: _____ Date: _____

Accident Information

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

Date of Accident: _____ Time: _____ Location: _____

Where you the DRIVER or PASSENGER (please circle one).

Your vehicle: Make: _____ Model: _____

Was another vehicle involved? ___ Yes or ___ No

Other vehicle(s): Make: _____ Model: _____

Was your vehicle accelerating? ___ Yes or ___ No

If yes, at what speed was your vehicle traveling? _____

What was your vehicle doing immediately prior to impact? (i.e. changing lanes, stopped, turning, etc.)

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

What was the amount of damage to your vehicle? _____

Did the police fill out an accident report? ___ Yes or ___ No

Does your vehicle have air bags? ___ Yes or ___ No

If yes, did the airbags deploy? ___ Yes or ___ No

Was your headrest properly adjusted? ___ Yes or ___ No

Does your seatbelt have a shoulder harness? ___ Yes or ___ No

Was your foot on the brake at the time of impact? ___ Yes or ___ No or ___ Don't remember

If yes, was your foot knocked off the brake at the time of impact? ___ Yes or ___ No

What was the position of your head/neck at the time of impact? _____

Did you lose consciousness at the time of impact? _____

Did any part of your body strike any part of your vehicle upon impact? ___ Yes or ___ No

Describe the accident:

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

Patient/Guardian Signature

Date