ULTIMATE HEALTH

Medical Clinic

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy statements. Please print clearly.

Ultimate Health Medical Clinic
7735 West Long Drive #11
Littleton, CO 80123
(303) 904-0331
www.uhmedical.com

__________________________ Today's Date (MM/DD/YYYY)

__________________________ Whom may we thank for referring you?

__________________________ Patient Number (office use only)

CONFIDENTIAL PATIENT INTAKE FORM (P.I)

Your Personal Information

______________________ Your First Name	______________________ Your Middle Name	______________________ Your Last Name
______________________ Address		
______________________ City	______________________ State	______________________ ZIP
______________________ Cell Phone	______________________ Home Phone	______________________ Email Address
______________________ Date of Birth	______________________ SSN	______________________ Driver's License Number
______________________ Height	______________________ Weight	______________________ Right/Left Handed?
Marital Status : S M D W	Gender: M F	
______________________	______________________ Was anyone else in the collision with you?	

Facts of the Collision

Date of Accident: _________________ Time: _______________________ Day of Week: _________________________

Weather (Sunny, Raining, Snowing, Icy, etc.):____

What street did it happen on? ____________________________________ County: ___________________________

Description of Accident/Event: ____

____

____

____

What type of vehicle were you in? ____

License Plate #:___________________ Who is the owner of the vehicle? ___________________________________

What type of vehicle was the other party driving? ____

Approximate speeds: Your vehicle: _________________ Other vehicle: _____________________

Your driver's foot position (gas, brake, clutch, both, neither, etc):____

What parts of the car, you were in, were damaged? ____

Cost of repairing your car: ___________ Where did you get the damage estimate at? ________________________________

Did either insurance company refer you to the garage that gave the estimate or where the car was repaired? __________________

Were you paid for vehicle damage? (Yes)_____ (No) _____ How much? ____

Where did you get the vehicle repaired? ____

Patient's insurance company? ____

Adjuster's Name: _____________________________________ Phone: ____

Address: ____ City: ____

State: ____ Zip Code: ____

Claim #:____ PIP Policy Limits:____

(UM/UIM)___________ Medical Insurance: ____________________ Med Pay? (Yes/No) Amount: _________________________

Did the police arrive? (Yes)___ (No)___ Which police department?____

Police officer's name: ______________________________ Was anyone cited? ____

Statements made at the scene by you or other party: ____

____

____

Have you made any statements to any insurance company or anyone else? If so, what was stated? ___________________________

____

____

Do you, or anyone else, have photographs of the accident scene, automobiles or your injuries? (Yes)__________ (No) ___________

If so, who? ____

Were any vehicles towed from the scene? (Yes) _____ (No) _____ If so, who's? (Mine)__________ (Other Driver's) __________

Information on Other Driver

Driver's Name: ______________________________________ Owner of vehicle: ___________________________________

Was this a company vehicle? (Yes)_____ (No) _____ Company name: ____

Driver's address: __________________________________ City: ____

State: ____________________ Zip Code: ____________________

Phone Numbers: (Home) ____________________ (Cell) ____________________

Date of Birth: ____________________ SSN: ____________________ Driver's License #: ____________________

Company/Owners Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

Phone Number: ____________________ State of Incorporation: ____________________

Driver's Insurance Company: ____________________ Adjustor: ____________________

Address: ____________________ City: ____________________

State: ____________________ Zip Code: ____________________

Phone Number: ____________________ Claim #:____________________

Damage done to their vehicle: ____________________ Estimated cost of repair: ____________________

Do you believe that any of the following were defective and resulted in either the accident itself or a worsening of your injuries?

(Road Signs) _____ (Roads) _____ (Traffic Signal) _____ (Brakes) _____ (Seat Belt) _____ Airbag) _____ (Seat) _____

Injuries, Impairment & Damages

Injuries as a result of the Accident / Event: ____________________

____

____

____

☐ Unknown

Which of the following do you suffer from now, which you did not prior to the accident?

☐ Headaches ☐ Dizziness ☐ Difficulty concentrating

☐ Long term memory loss ☐ Short term memory loss ☐ Amnesia

☐ Loss of consciousness at scene ☐ "Blackouts" since collision ☐ Forgetting ATM or PIN #s

☐ Reading problems ☐ Writing problems ☐ Typing problems

☐ Apathy ☐ Irritability ☐ Sleep disturbances

☐ Personality changes ☐ Emotional difficulties ☐ Relationship difficulties

☐ Blurred vision ☐ Photophobia (sensitivity to light) ☐ Vision changes

☐ Intolerance to alcohol ☐ Intolerance to heat ☐ Intolerance to cold

☐ Impaired comprehension	☐ Impaired learning	☐ Attention impairment
☐ Loss of libido	☐ Missing periods of time	☐ Speech difficulties
☐ Concussion in collision	☐ Nausea	☐ Vomiting
☐ Extreme thirst since collision	☐ Fatigue	☐ Menstrual irregularities
☐ Tinnitus (ringing in ears)	☐ Noise intolerance	☐ Loss of coordination
☐ Bumping into objects in view	☐ Loss of balance	☐ Fluid in ears
☐ Hearing loss	☐ Vertigo (spinning sensation)	☐ Increased symptoms in crowds
☐ Anxiety	☐ Depression	☐ Insomnia
☐ Flashbacks to accidents scene	☐ Intrusive thoughts of accident	☐ Nightmares since collision
☐ Unusual behavior since collision	☐ Social withdrawal	☐ Panic attacks
☐ Thoughts of death/suicide	☐ Weight loss/gain _________lbs	☐ Loss of taste/smell
☐ Blackouts with neck movements	☐ Dizziness with neck movements	☐ "Clunk" sound with moving neck
☐ Jaw pain	☐ Clicking in jaw	☐ Pain with chewing

Numbness/Tingling/Weakness in arms	Yes	No	R	L	Level(s)_____________________________
Numbness/Tingling/Weakness in legs	Yes	No	R	L	Level(s)_____________________________
Seatbelt:___________________________	Did the seatbelt bruise you?___________				If so, where?________________________
Head/Body position:	☐ Straight	☐Right rotated	☐ Left rotated	☐ Up	☐ Down
Was the type of impact of the vehicles:	☐ Head on	☐ Right side	☐ Left side	☐ Oblique angle	☐ Rear end

Where was the headrest located before impact? ☐Upper back ☐Mid neck ☐Mid head ☐Upper head ☐None

Did your head or body strike anything inside the car? ☐Yes ☐No If so, what? ____

Did you lose consciousness? ☐Yes ☐No

Did the items in the car get displaced? If so, what?______________________

Did your airbag(s) deploy? ☐Yes ☐No

Did your seats break? ☐Yes ☐No

Ambulance Companies

Company	Date	From	To
1.			
2.			

Impaired Activities

Circle all activities which have been impaired in any way by the accident in question.

Daily Activities

bathing/showering	bending	brushing teeth	dressing	driving car
vacationing	dining out	movie going	standing	sitting
sexual relations	lifting	church events	child care	religious activities
washing hair	eating	moving	reading	shaving
shopping	watching TV	sleeping	traveling	social events

Domestic Activities (Activities within the home)

bending	cooking	ironing	housecleaning	laundry
washing dishes	vacuuming	dusting	interior painting	decorating

Household Activities (Activities outside the home)

trimming bushes	gardening	tree trimming	mowing lawn	yard work
exterior painting	car washing	landscaping	house maintenance	farm activities

Work Activities

sitting	standing	lifting	using telephone	computer work
reading	bending	typing	writing	child care

Hobby Activities

aerobic exercises	archery	backpacking	bowling	badminton
baseball	basketball	basketry	bicycling	boxing
card playing	camping	dancing	fencing	fishing
flying	football	gardening	golf	handball
gymnastics	health clubs	hockey	hunting	judo
horseback riding	ice skating	karate	painting	yoga
jogging/running	photography	racquetball	rafting	sailing
mountain climbing	sewing	snow skiing	swimming	walking
musical instruments	volleyball	water skiing	water sports	weight lifting

Activities which you have performed despite pain, due to financial, family or personal needs (Duties under Duress):

☐Work ☐Education ☐Domestic (Activities within the home) ☐Household (Duties outside the home)

Past motor vehicle accidents, workers compensation claims, or other claims of any sort:____________________________________

____

____

____

____

____

____

____

Name of your regular doctor:___________________________ Phone:____

Address:____________________________________ City:___________________________ State:_________ Zip Code:____________

List all other past doctors or other health care providers (medical and alternative) you have seen and include their addresses, the dates or time periods in which you saw them, the reasons for seeing them, the types of treatment given to you, and whether they might have any information that would help us compare your present health with your health before the collision (excluding those noted above).

1.____

2.____

3.____

4.____

List, as carefully and accurately as you can, all injuries, illnesses, or medical conditions you have had in your life, even if they have no similarity to the injuries that you received in this collision. Include the approximate dates, the cause of the injuries, the doctors who treaded you and whether you fully recovered from these problems. If any lawsuit or claim was made for any of those injuries please state.

____

____

____

____

____

____

____

____

____

Patient Name:____________________________ Signature:_____________________________ Date:_________________

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, **but please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity
☐ I have no pain at the moment
☐ The pain is mild at the moment
☐ The pain comes and goes and is moderate
☐ The pain is moderate and does not vary much
☐ The pain is severe but it comes and goes
☐ The pain is severe and does not vary much

Section 2 – Personal Care (Washing, Dressing, etc.)
☐ I can look after myself without causing extra pain
☐ I can look after myself normally but is causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but manage most of my personal care
☐ I need help every day in most aspects of self-care
☐ I do not get dressed, I was with difficulty and stay in bed

Section 3 – Lifting
☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives extra pain
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
☐ I can lift very light weights
☐ I cannot lift or carry anything at all

Section 4 – Reading
☐ I can read as much as I want to with no pain in my neck
☐ I can read as much as I want to with slight pain in my neck
☐ I can read as much as I want to with moderate pain in my neck
☐ I cannot read as much as I want because of moderate pain in my neck
☐ I cannot read as much as I want because of severe pain in my neck

Section 5 – Headaches
☐ I have no headaches at all
☐ I have slight headaches which come infrequently
☐ I have moderate headaches which come infrequently
☐ I have moderate headaches which come frequently
☐ I have severe headaches which come frequently
☐ I have headaches almost all of the time

Section 6 – Concentration
☐ I can concentrate fully when I want to with no difficulty
☐ I can concentrate full with I want to with slight difficulty
☐ I have a fair degree of difficulty in concentrating when I want to
☐ I have a lot of difficulty in concentrating when I want to
☐ I have a great deal of difficulty in concentrating when I want to

Section 7 – Work
☐ I can do as much work as I want to
☐ I can only do my usual work, but no more
☐ I can do most of my usual work, but no more
☐ I cannot do my usual work
☐ I can hardly do any work at all
☐ I cannot do any work at all

Section 8 – Driving
☐ I can drive my car without neck pain
☐ I can drive my car as long as I want with slight pain in my neck
☐ I can drive my car as long as I want with moderate pain in my neck
☐ I cannot drive my car as long as I want because of moderate pain in my neck
☐ I cannot drive my car at all

Section 9 – Sleeping
☐ I have no trouble sleeping
☐ My sleep is slightly disturbed (less than 1 hour of sleeplessness)
☐ My sleep is mildly disturbed (1-2 hours of sleeplessness)
☐ My sleep is moderately disturbed (2-3 hours of sleeplessness)
☐ My sleep is greatly disturbed (3-5 hours of sleeplessness)
☐ My sleep is completely disturbed (5-7 hours of sleeplessness)

Section 10 – Recreation
☐ I am able to engage in all recreational activities with no pain in my neck at all
☐ I am able to engage in all recreational activities with some pain in my neck
☐ I am able to engage in most, but not all, recreational activities because of the pain in my neck
☐ I am able to engage in a few of my usual recreational activities because of the pain in my neck
☐ I can hardly do any recreational activities because of the pain in my neck.
☐ I cannot do any recreational activities at all

Patient Name:____________________________ Signature:_____________________________ Date:_________________

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, **but please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity
☐ The pain comes and goes and is very mild
☐ The pain is mild and does not vary much
☐ The pain comes and goes and is moderate
☐ The pain is moderate and does not vary much
☐ The pain is comes and goes and is severe
☐ The pain is severe and does not vary much

Section 2 – Personal Care (Washing, Dressing, etc.)
☐ I do not have to change my way of washing or dressing in order to avoid pain
☐ I do not normally change my way of washing or dressing even though it causes some pain
☐ Washing and dressing increase the pain but I manage not to change my way of doing it
☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it
☐ Because of the pain I am unable to do some washing and dressing without help
☐ Because of the pain I am unable to do any washing and dressing without help

Section 3 – Lifting
☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives extra pain
☐ Pain prevents me from lifting heavy weights off the floor
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table
☐ I can only lift very light weights at most

Section 4 – Walking
☐ I have no pain walking
☐ I have some pain with walking but it does not increase with distance
☐ I cannot walk more than one mile without increasing pain
☐ I cannot walk more than 1/2 mile without increasing pain
☐ I cannot walk more than 1/4 mile without increasing pain
☐ I cannot walk at all without increasing pain

Section 5 – Sitting
☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair for as long as I like
☐ Pain prevents me from sitting more than one hour
☐ Pain prevents me from sitting more than 30 minutes
☐ Pain prevents me from sitting more than 10 minutes
☐ I avoid sitting because it increases pain straight away

Section 6 – Standing
☐ I can stand as long as I like without pain
☐ I have some pain on standing but it does not increase with time
☐ I cannot stand for longer than one hour without increasing pain
☐ I cannot stand for longer than 1/2 hour without increasing pain
☐ I cannot stand for longer than 10 minutes without increasing pain
☐ I avoid standing because it increases pain straight away

Section 7 – Sleeping
☐ I get no pain in bed
☐ I get pain in bed but it does not prevent me from sleeping well
☐ Because of pain my normal night’s sleep is reduced by less than ¼
☐ Because of pain my normal night’s sleep is reduced by less than 1/2
☐ Because of pain my normal night’s sleep is reduced by less than ¾
☐ Pain prevents me from sleeping at all

Section 8 – Social Life
☐ My social life is normal and gives me no pain
☐ My social life is normal but increases the degree of my pain
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
☐ Pain has restricted my social life and I do not go out very often
☐ Pain has restriped my social lie to my home
☐ I have hardly any social life because of the pain

Section 9 – Traveling
☐ I have no pain while traveling
☐ I get some pain while traveling but none of my usual sorts of travel make it any worse
☐ I get extra pain while traveling but it does not compel me to seek alternate forms of travel
☐ Pain restricts all forms of travel
☐ Pain prevents all forms of travel except that done lying down

Section 10 – Changing Degree of Pain
☐ My pain is rapidly getting better
☐ My pain fluctuates but overall is definitely getting better
☐ My pain seems to be getting better but improvement is slow at the present
☐ My pain is neither getting better or worse
☐ My pain is gradually worsening
☐ My pain is rapidly worsening