

BRANDON INJURY AND WELLNESS CENTER BRANDON, FL 33511 PH (656) 500-9969 FAX (813) 657-7077

PATIENT INTAKE FORM - PLEASE PRINT

PERSONAL INFORMATION					
NAME EMAIL					
FIRST MIDDLE - MAIDEN LAST					
DATE OF BIRTH GENDER MARITAL STATUS SINGLE / MARRIED / DIVORCED					
MAILING ADDRESS NUMBER & STREET CITY STATE ZIP					
PHONE ALT PHONE SOCIAL SECURITY NO					
Our practice uses text messages to communicate with our patients. We will use text messaging to communicate your next appointment date and office closures. We will use text message information via text message. By providing your cell phone number and signature, you agree to receive text messages from Brandon Injuyr and Wellr *Data plan charges may apply*:	vill never ness Center.				
CELL PHONE NO PATIENT SIGNATURE					
EMERGENCY CONTACT					
NAME					
RELATIONSHIPOCCUPATION					
PHONE					
ACCIDENT INFORMATION					
Have you lost time from work as a result of this accident? \square Yes \square No					
If yes please complete details below					
Dates missed Type of work					
AUTO INSURANCE INFORMATION					
ASTO INSCIDINCE IN CHARLES					
NAME OF INSURED					
EFFECTIVE DATE					
RELATIONSHIP TO INSURED					
NAME OF AUTO INSURANCE COMPANY					
ADDRESS PHONE					
NUMBER & STREET CITY STATE ZIP					



WELLNESS CENTER

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PLEASE PRINT

PAST MEDICAL HISTORY						
There were / were not in Explain injury, if applicable	juries. :	er accidents. If so, when?				
I was treated by:						
I was / was not still unde	r care for those injuries at the	time of this current accident w	ith Dr			
Have you had any of the fol	llowing illnesses? Check all th	nat apply.				
Chronic Fatigue Colitis Congenital Heart Disease Constipation	Goiter Gout Hay Fever Headaches: Migraine Sinus Tension Hearing Problems Heart Attack	Kidney Disease Kidney or Bladder Infections (frequent) Lung Disease Lung Infections (frequent) Other Medical Problems: Nausea Nervous Breakdown Pacemaker / Stents Polio Rashes Sexually Transmitted: AIDS, Syphilis, HIV Gonorrhea, Herpes Shortness of Breath Sickle Cell Anemia	Seizures Stomach Pain Stomach Ulcer Stroke Swollen Joints Thyroid Disease Tuberculosis Urinary Problems Vision Problems Vomiting Childhood Diseases: Chicken Pox Measles Mumps Rheumatic Fever Whooping Cough			
HOSPITALIZATIONS						
		dates:				
I have / have never had surgery. Name procedures and dates:						
Do you have surgical scars?	YES NO If so, indicate v	vhere?				
Any other past medical history the doctor should know?						
Any surgical implants? Y		escribe.				
Are you pregnant? YES	NO					



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ACCIDENT QUESTIONNAIRE

PATIENT DETAILS						
Accident/Injury Type □ Auto □ Slip/Fall □ C	n the Job 🗆	l Other:				
Date of Accident/Injury	ate of Accident/Injury Location					
Were you wearing a seatbelt? ☐ Yes ☐ No				No		
You were the $\ \square$ Driver $\ \square$ Passenger - $\ \square$ From	nt seat 🗆 Ba	ck seat				
In your own words, please describe the accident/in	ury	_				
Were you struck in the ☐ Front ☐ Rear ☐ Dri	ver's side 🛚	Passeng	er's side			
Were you knocked unconscious?	☐ Yes	□No	If yes for how long?			
Were you examined by paramedics, EMT or any oth	er first respon	der afte	the accident?	□No		
Did you go to the hospital?	☐ Yes	□No	If yes, name of Hospi	tal ———		
Drivin to the Hospital by	☐ Amb	ulance	☐ Self ☐ Other —			
Were X-Rays taken?	☐ Yes	□No				
Were you given medication?	☐ Yes	□No				
Were you told the diagnosis?	☐ Yes	□No	If yes please describe	!		
Have you been treated since the accident?				doctor's name, address, and	treatment b	pelow
Name	Address	- NUMBER O	TDFFT	CITY STATE		ZIP
Describe treatment		NUMBER &	DIRECT	CITY STATE	<u> </u>	ZIP
Have you ever had similar symptoms prior to the accident/injury? ☐ Yes ☐ No If yes please describe						
Have you ever been involved in an accident before?						
REVIEW OF SYSTEMS						
Do you currently have any of the follo	owing? Ch	eck all	that apply.			
Headaches Stomach	Pain	Che	st Pain	Vision Problems		Nausea
Shortness of Breath Hearing F	roblems	Von	niting	Urinary Problems		Dizziness
Constipation Rashes Chronic Fatigue		Dia	Thea	Difficulty Swallowin	ng	Swollen Joints



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PATIENT INJURY IDENTIFICATION

SELECT ALL SY	MPTOMS THAT APPEARED AS A RESULT OF YOUR ACCIDENT/INJURY
DIFFICULTY:	H:□ ANXIOUS / NERVOUS TO DRIVE / RIDE IN A CAR □ PANIC ATTACKS / ANXIETY □ NIGHTMARES □ DEPRESSION □ IRRITABLE □ FATIGUE □ FORGETFULNESS □ WEIGHT GAIN □ WEIGHT LOSS □ CONCENTRATING □ READING □ WRITING □ SLEEPING □ SHORT TERM □ LONG TERM □ BOTH
HEAD:	☐ HEADACHE ☐ BLURRED VISION ☐ DIZZINESS RINGING IN EARS ☐ LOSS OF BALANCE ☐ LOSS OF COORDINATION ☐ LACK OF BALANCE OR DIZZINESS WHEN TURNING HEAD ☐ PAIN WHEN CHEWING ☐ CLICKING SENSATION WHEN CHEWING
NECK:	□ PAIN □ STIFFNESS □ HEAVINESS □ POPPING OR CRUNCHING SENSATION
UPPER BODY:	LOSS OF RANGE OF MOTION IN SHOULDERS: LEFT RIGHT BOTH PAIN WHEN MOVING SHOULDERS: LEFT RIGHT BOTH NUMBNESS/TINGLING DOWN ARM: LEFT RIGHT BOTH ELBOW PAIN: LEFT RIGHT BOTH WRIST PAIN: LEFT RIGHT BOTH NUMBNESS/TINGLING IN HAND: LEFT RIGHT BOTH WEAKNESS IN HAND: LEFT RIGHT BOTH
BACK:	BACK PAIN FROM PROLONGED PERIOD OF TIME: ☐ SITTING ☐ STANDING ☐ TROUBLE BENDING OVER ☐ TROUBLE GETTING STRAIGHT AGAIN AFTER BENDING OVER
LOWER BODY:	HIP PAIN: LEFT RIGHT BOTH PAIN GOING INTO THE BUTTOCKS: LEFT RIGHT BOTH GOING DOWN THE LEGS: PAIN NUMBNESS LEFT RIGHT BOTH PAIN/ NUMBNESS GOING DOWN THE LEGS TRAVELS INTO: CALF FOOT KNEE PAIN: LEFT RIGHT BOTH ANKLE PAIN: LEFT RIGHT BOTH
OTHER:	☐ BRUISING FROM THE SEATBELT — LOCATION OF BRUISING: LIST ANY OTHER CUTS, BRUISES, OR ABRASIONS FROM THE ACCIDENT:
	☐ OTHER SYMPTOMS/PROBLEMS NOT LISTED:
	☐ ANY PREVIOUS INJURIES/SURGERIES THAT HAVE BEEN RESOLVED, BUT NOW HAVE BEEN MADE WORSE SINCE THE ACCIDENT: