Apex Healthcare & Rehab, PC

Accident Intake Questionnaire

Name _____ Age_____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell (____) _____ Cell Carrier _____ Home (____) _____ Work (____) _____

Date of Birth: _____ Sex: ❑ Male ❑ Female SS#: _____ Email: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____ Phone: _____

Referring Doctor/Office: _____ Attorney Name and Phone: _____

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Date of the Accident: _____ Insurance Co: _____ Phone #: _____

Adjuster/Claim Rep:_____ Claim #: _____ Briefly describe accident below:

Height: _____ Weight:_____ List any Allergies: _____
Please list all prescription medications you are currently taking: _____
Do you have a Primary Care Doctor ❑ Yes ❑ No Name: _____ Phone: _____
Past Surgeries (please list):_____

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Anxiety	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Heart Disease	❑ Heart Disease	❑ Pacemaker	❑ Suicide Attempt
❑ Allergies	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Multiple Sclerosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Other_____				

I, _____ (print name) certify that the above questions were answered accurately and to the best of my knowledge.

_____ (patients signature) _____ Date _____(Witness Signature) _____ Date