## Apex Healthcare & Rehab, PC



## Accident Intake Questionnaire

\_\_\_\_\_(Witness Signature) \_\_\_\_\_ Date

Name			Age	Date:
Address:		City:	State:	Zip:
Cell ()	Cell Carrier	Home (	_) w	ork ()
Date of Birth:	Sex: 🗖 Male 🗆	Female SS#:		Email:
Marital Status: 🚨	Single   Married	☐ Divorced ☐ Wid	owed 🗖 Separated	☐ Minor
Occupation:		Employer:		
Emergency Contact:	:	Relationship:	Phone:	
Do you have health	insurance? $\square$ Yes $\square$	No Name of Carri	er:	Phone:
Referring Doctor/Of	fice:	Attorney Name and	Phone:	
Is this visit due to a	n accident? 🔲 Yes 🗖	No If yes, what ty	pe? 🗖 Auto 🗖 Wo	rk 🗖 Other
Date of the Acciden	t: Insu	rance Co:	Phone #: _	
Adjuster/Claim Rep	: CI	aim #:	Briefly de	escribe accident below:
	ht: List any Alle			
Please list all prescript	ion medications you are co	urrently taking:		
Please list all prescript Do you have a Primary	ion medications you are co	urrently taking: Name:		Phone:
Please list all prescript Do you have a Primary Past Surgeries (please	ion medications you are co Care Doctor  Yes  No list):	urrently taking: o Name:		Phone:
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat	ion medications you are concared to Care Doctor	urrently taking:o Name:	owing conditions:	Phone:
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat  Neck Pain/Stiffness	ion medications you are concared to Care Doctor	o Name:eriencing any of the follo	owing conditions:	Phone: Nausea
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat  Neck Pain/Stiffness Back Pain/Stiffness	ion medications you are concared to Care Doctor	eriencing any of the followants:  Anxiety  Depression	owing conditions:  Sudden Weight Loss Loss of Taste	Phone:  Nausea Cold Feet
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat Neck Pain/Stiffness Back Pain/Stiffness Arm/Hand Pain	ion medications you are concared to Care Doctor	eriencing any of the followant Depression  Nervousness	owing conditions:  Sudden Weight Loss Loss of Taste Loss of Memory	Phone:  Nausea Cold Feet Chest Pain
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat Neck Pain/Stiffness Back Pain/Stiffness Arm/Hand Pain Leg/Knee Pain	ion medications you are concluded.  Care Doctor Yes No list):  te if you are currently expended in Arms Pins/Needles in Legs Fatigue Sleeping Difficulties	eriencing any of the followard Depression  Nervousness Tension	owing conditions:  Sudden Weight Loss Loss of Taste Loss of Memory Jaw Problems	Phone:  Nausea Cold Feet Chest Pain Fever
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat Neck Pain/Stiffness Back Pain/Stiffness Arm/Hand Pain Leg/Knee Pain Headaches	ion medications you are concare Doctor  Yes  No list):  te if you are currently expended  Pins/Needles in Arms   Pins/Needles in Legs   Fatigue   Sleeping Difficulties   Loss of Smell	eriencing any of the followard Depression Nervousness Tension Cold Sweats	bwing conditions:  Sudden Weight Loss Loss of Taste Loss of Memory Jaw Problems Constipation	Phone:  Nausea Cold Feet Chest Pain
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat Neck Pain/Stiffness Back Pain/Stiffness Arm/Hand Pain Leg/Knee Pain	ion medications you are concluded.  Care Doctor Yes No list):  te if you are currently expended in Arms Pins/Needles in Legs Fatigue Sleeping Difficulties	eriencing any of the folkong Anxiety Depression Nervousness Tension Cold Sweats Stomach Problems	Dwing conditions:  Sudden Weight Loss Loss of Taste Loss of Memory Jaw Problems Constipation Shortness of Breath	Phone:  Nausea Cold Feet Chest Pain Fever Fainting
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat Neck Pain/Stiffness Back Pain/Stiffness Arm/Hand Pain Leg/Knee Pain Headaches Dizziness	ion medications you are concare Doctor  Yes  No list):  te if you are currently expended  Pins/Needles in Arms   Pins/Needles in Legs   Fatigue   Sleeping Difficulties   Loss of Smell   Allergies	eriencing any of the followard Depression Nervousness Tension Cold Sweats	bwing conditions:  Sudden Weight Loss Loss of Taste Loss of Memory Jaw Problems Constipation	Phone:  Nausea Cold Feet Chest Pain Fever Fainting
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat Neck Pain/Stiffness Back Pain/Stiffness Arm/Hand Pain Leg/Knee Pain Headaches Dizziness Asthma	ion medications you are concare Doctor  Yes  No list):  te if you are currently expended  Pins/Needles in Arms   Pins/Needles in Legs   Fatigue   Sleeping Difficulties   Loss of Smell   Allergies	eriencing any of the followard for the followard	Dwing conditions:  Sudden Weight Loss Loss of Taste Loss of Memory Jaw Problems Constipation Shortness of Breath	Phone:  Nausea Cold Feet Chest Pain Fever Fainting
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Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicate Neck Pain/Stiffness Back Pain/Stiffness Arm/Hand Pain Leg/Knee Pain Headaches Dizziness Asthma  Please check to indicate Aids/HIV	ion medications you are concare Doctor  Yes  No list):  te if you are currently experience  Pins/Needles in Arms   Pins/Needles in Legs   Fatigue   Sleeping Difficulties   Loss of Smell   Allergies   Blurred Vision  te if you have ever had any   Cancer   Heart Disease   Chemical Dependency	eriencing any of the following:  Cold Sweats Cold Swea	Dwing conditions:  Sudden Weight Loss Loss of Taste Loss of Memory Jaw Problems Constipation Shortness of Breath Bowel/Bladder Chang	Phone:  Nausea Cold Feet Chest Pain Fever Fainting ges
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicate Neck Pain/Stiffness Back Pain/Stiffness Arm/Hand Pain Leg/Knee Pain Headaches Dizziness Asthma  Please check to indicate Aids/HIV Alcoholism	ion medications you are concare Doctor  Yes  No list):  te if you are currently experience  Pins/Needles in Arms   Pins/Needles in Legs   Fatigue   Sleeping Difficulties   Loss of Smell   Allergies   Blurred Vision  te if you have ever had any   Cancer   Heart Disease   Chemical Dependency   Chicken Pox	eriencing any of the following:  Cold Sweats Stomach Problems Night Pain  Hepatitis Heart Disease Herniated Disc Herpes	Dwing conditions:  Sudden Weight Loss Loss of Taste Loss of Memory Jaw Problems Constipation Shortness of Breath Bowel/Bladder Change	Phone:  Nausea Cold Feet Chest Pain Fever Fainting ges  Stroke Suicide Attempt
Please list all prescript Do you have a Primary Past Surgeries (please  Please check to indicat Neck Pain/Stiffness Back Pain/Stiffness Arm/Hand Pain Leg/Knee Pain Headaches Dizziness Asthma  Please check to indicat Aids/HIV Alcoholism Allergies Anemia Anorexia	ion medications you are concare Doctor  Yes  No list):  te if you are currently experience  Pins/Needles in Arms   Pins/Needles in Legs   Fatigue   Sleeping Difficulties   Loss of Smell   Allergies   Blurred Vision  te if you have ever had any Cancer   Heart Disease   Chemical Dependency   Chicken Pox   Diabetes	eriencing any of the following:  Cold Sweats Cold Swea	Dowing conditions:  Sudden Weight Loss Loss of Taste Loss of Memory Jaw Problems Constipation Shortness of Breath Bowel/Bladder Change Osteoporosis Pacemaker Parkinson's Disease Pinched Nerve Pneumonia	Phone:  Nausea Cold Feet Chest Pain Fever Fainting  ges  Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis
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\_\_ (patients signature) \_\_\_\_\_ Date