



Personal Injury Patient Health Questionnaire

Name: _____ Nickname: _____ Date: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____

What was the exact date of your car accident? Month _____ Day _____ Year _____

Was the accident your fault? ☐ Yes ☐ No Do you have Health insurance ☐ Yes ☐ No

Who was ticketed for the car accident? _____ Please provide our office with a copy of the police report.

How did the car accident occur? _____

Year & Model of your vehicle _____ Was your car totaled? ☐ Yes ☐ No

Location of accident (including City and State)

Do you have med-pay coverage? ☐ Yes ☐ No If so, how much _____

Do you have uninsured or underinsured motorist coverage? ☐ Yes ☐ No

Have you informed your auto insurance of this accident? ☐ Yes ☐ No When _____

Do you have an Attorney? ☐ Yes ☐ No If so, provide all the information below

Attorney name (_____) - Attorney phone number

Attorney address (_____) - Attorney fax number

Insurance company name (Your Car) Policy number Claim number

Policy holder's name (from card) (_____) Insurance Phone Number

Insurance Company name (Other car) Policy number Claim number

Policy holder's name (from card) (_____) Insurance Phone Number

Where did the accident occur? ☐ City street ☐ Highway ☐ Stoplight or sign ☐ Intersection ☐ Other

Were you wearing your seatbelt? ☐ Yes ☐ No

Did your body hit anything in the car upon impact? _____

Where were you sitting at the time of the accident? ☐ Driver ☐ Passenger ☐ Backseat

Did you experience symptoms immediately after car accident? ☐ Yes. If no when _____

Have you received medical attention since the car accident? ☐ Yes ☐ No

If Yes Where? ☐ Emergency Room ☐ Urgent Care ☐ Primary Care ☐ Chiropractor

☐ Orthopedist ☐ Other Name of physician or facility? _____

Have you undergone diagnostic imaging since the accident? ☐ Yes ☐ No

If Yes What? ☐ X-rays ☐ CT scan ☐ MRI ☐ Other _____

If Yes, what body part? _____ **What facility?** _____

What were the results of the Imaging? ☐ Fracture ☐ Soft Tissue Injury ☐ Disc injury ☐ Unknown
Please provide our office with any copies of Dr. visits and imaging reports.

Did you have surgery for this condition? ☐ Yes, ☐ No Surgeon Name _____

Date of surgery: Month _____ Day _____ Year _____

Did you have previous problems with your injury before the car accident? ☐ Yes ☐ No

What other treatment are you currently receiving for this condition? ☐ Medication ☐ Injections

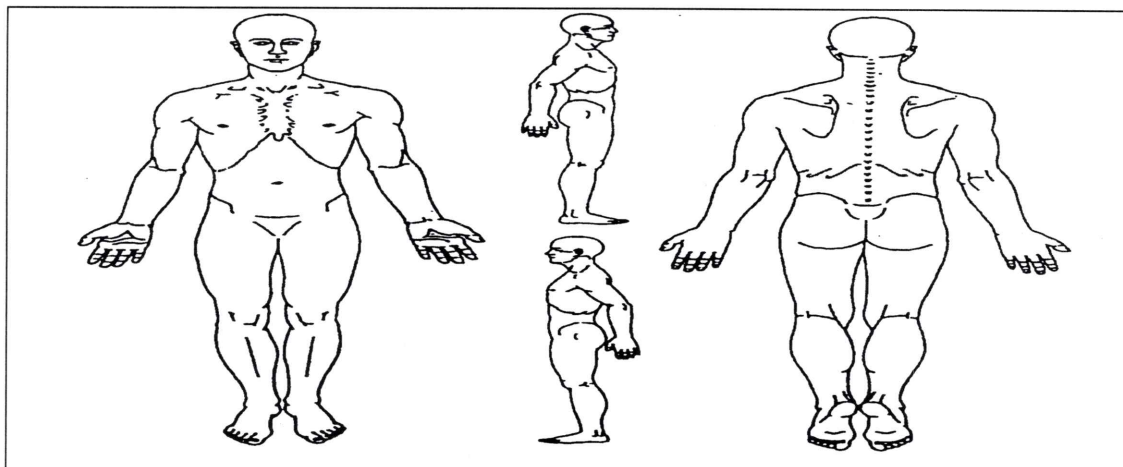
☐ Chiropractic ☐ Other _____

Since the injury are your symptoms getting ☐ Better? ☐ Worse? ☐ Same?

Please list other pertinent medical conditions that might affect your treatment:

What is your primary goal in Physical Therapy: _____

***On below chart please mark (X) location of your injury:**



Please rate your pain on a scale of 0 – 10 with (0) being no pain and (10) being the worst.

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10

Describe your pain: (Mark only the **one** that best describes)

☐ Sharp, ☐ Dull / Achy, ☐ Burning, ☐ Shooting, ☐ Numbness/Tingling, ☐ Constant,

☐ Intermittent ☐ Worse in am, ☐ Worse in pm

Aggravating Factors: ☐ Sitting, ☐ Standing, ☐ Walking, ☐ Stairs, ☐ Sit to stand, ☐ Bending,

☐ Lifting, ☐ Sleeping, ☐ Squatting, ☐ Carrying, ☐ Reaching Overhead, ☐ Handling objects,

☐ Pushing, ☐ Pulling, ☐ Running, ☐ Jumping, ☐ Exercise

Alleviating Factors: ☐ Sitting, ☐ Standing ☐ Walking, ☐ Lying Down, ☐ On the move,

☐ When still, ☐ As the day progresses

Medications you are taking related to your injury: ☐ Prescription pain, ☐ Over the counter pain,

☐ Anti-inflammatory, ☐ Other _____

Check if you have, or have ever had any of the following conditions:

☐ Abdominal Aneurysm, ☐ Pacemaker, ☐ Diabetes Type 1, ☐ Diabetes Type 2 ☐ Stroke

☐ High Blood Pressure, ☐ HIV (+), ☐ Heart Attack, ☐ Fibromyalgia, ☐ Rheumatoid Arthritis,

☐ Osteo Arthritis ☐ Currently Pregnant ☐ Cancer, What type _____ ☐ Are you in remission



Patient Information

Patient Last Name First Name Middle Initial Home Phone number (____)____-____ Cell Phone Number (____)____-____

Street Address City State Zip

____/____/____ Age Sex Social Security Number Marital Status

**If you would like to receive a reminder by email, text or voice call for your visits, provide the info below:
(Circle one)**

E-mail Address: _____ Phone (____)____-_____

Employer's Name Employer's Phone (____)____-_____

Name of Primary Care Physician Primary Care Physicians Phone Number (____)____-_____

Referring Doctor Referring Doctor Phone Number (____)____-_____

How did you hear about our facility?

SPOUSE/ PARENT (IF NOT MARRIED) INFORMATION

Last Name First Name Initial Date of Birth

Their Employer's Name Employer's Phone (____)____-_____

WHO CAN WE CALL IN CASE OF AN EMERGENCY

Their Name Relation to Patient Phone Number (____)____-_____

***** Is my referral due to a Workers Comp, Motor Vehicle Accident, or Slip and Fall Personal Injury?**
Yes No Circle one if Yes



Patient Information

Please present your insurance card to the receptionist when you hand in your paper work. Thank you.

Primary Insurance Company Name Policy Number Group Number

Policy Holder's Name (from card) Social Security Number Date of Birth

Secondary Insurance Company Name Policy Number Group Number

Policy Holder's Name (from card) Social Security Number Date of Birth

RESPONSIBILITY STATEMENT & RELEASE OF INFORMATION

I understand that I am responsible for paying for all medical services not covered by an authorization/agreement between Physical Rehabilitation Center of Tulsa and my insurance carrier or attorney. I authorize the release of any or all of the patient's medical records for this period of care to any person/corporation liable for any part of the physician charges and the patient's attorney. Oklahoma state law requires that we advise "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS)."

Print Patient or Legal Guardian Name

Patient or Legal Guardian Signature

Date



Notice of Receipt of Privacy Notice of Physical Rehabilitation Center of Tulsa

By signing below, I acknowledge that I have received and reviewed the Privacy notice of Physical Rehabilitation Center of Tulsa, in force as of April 14, 2003 and all of my questions have been answered to my satisfaction in language that I can understand.

Name of Individual (Printed)

Signature of individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian,
Parent if a minor):

Relationship

Date Signed ____/____/____

Witness: _____



AUTHORIZATION & ASSIGNMENT FORM

In consideration of Physical Rehabilitation Center of Tulsa (PRC) undertaking to care for me, I agree to the following:

1. PRC is authorized to release any information they deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment in full to PRC of any sum I now or hereafter owe PRC, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to PRC for the charges made for the services refuses to make such payment upon demand by PRC, I hereby assign and transfer to PRC the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize PRC to prosecute said action in my name as you see fit. I understand that whatever amounts PRC does not collect from the insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to PRC. I also agree that PRC may elect, in its sole discretions, to seek payment in full from any and all applicable insurance sources and shall not be obligated to accept adjusted payment amounts from my health insurer as payment in full if other insurance coverage also applies or provides coverage for the charges incurred.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Oklahoma.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and assignment will be in continual effect until revoked by both parties in writing.

Patient or Legal Guardian Signature

Date

Patient Printed Name



PATIENT AUTHORIZATIION USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Physical Rehabilitation Center of Tulsa disclose protected health information that pertains to me to the following person(s):

I expressly acknowledge that this authorization is voluntary. The following are other criteria or limitations that I make regarding this authorization:

I understand that I may revoke this authorization at any time by signing the revocation section of this form. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

Signature

Date

REVOCATION SECTION

I hereby revoke this authorization to disclose protected health information to the above stated person(s).

Signature

Date