New Patient Information - Motor Vehicle Accident

Optima Cl inic, LLC
503.526.0734/ FAX 503.715.3182

Name: ______________________ Date: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

Home Phone: ______________________ Work Phone: ______________________

Date of Birth: ______________________ Social Security No: ______________________

Occupation: ______________________ Employer: ______________________

ODL: ______________________ Email (optional) ______________________

In case of emergency, please contact:

Name: ______________________ Phone: ______________________

Referring Physician: ______________________ Phone: ______________________

Accident Information

Date of Accident ______________________ Time of Accident ______________________

Were you the ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

Please describe the accident in your own words: ______________________

____

Your vehicle make and model: ______________________

Were you wearing a seatbelt? ☐ Yes ☐ No If so, what type? ☐ Shoulder ☐ Lap

Was the vehicle equipped with airbags? ☐ Yes ☐ No If yes, did they inflate properly? ☐ Yes ☐ No

Did your vehicle have a headrest? ☐ Yes ☐ No If yes, what position was it in? ☐ Low ☐ Mid ☐ High

Did your car impact another car? ☐ Yes ☐ No Did your car impact a structure? ☐ Yes ☐ No

Did any part of your body strike anything in the vehicle? ☐ No ☐ Yes

If yes, please describe: ______________________

Was the impact from the ☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other ______________________

At the time of impact where were you looking? ______________________

Were both hands on the steering wheel? ☐ Yes ☐ No If no, which was on the wheel? ☐ L ☐ R ☐ Neither

Was your foot on the brake? ☐ Yes ☐ No If yes, which foot was on the brake? ☐ L ☐ R

Were you ☐ Surprised by the impact ☐ Braced for the impact

What speed were you traveling? __________ What speed was the other car traveling? __________

Driving conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other

Client Condition

Were you unconscious immediately after the accident? ☐ Yes ☐ No

Please describe how you felt immediately after the accident: ______________________

____

Treatment

Did you go the the hospital (urgent care)? ☐ Yes ☐ No

Were X-rays taken? ☐ Yes ☐ No MRI/CTscan? ☐ Yes ☐ No

When did you go? ☐ Immediately after the accident ☐ The next day ☐ 2 days or more after

Diagnosis ______________________________

Treatment received ______________________________

Symptoms and/or Injuries

Have you been able to work or attend school since the injury? ☐ Yes ☐ No

Have you missed and time at work/school since the injury? ☐ Yes ☐ No

Has this injury affected your work performance? ☐ Yes ☐ No

If yes, how? ______________________________

Please list other activities affected by your injury: ______________________________

____

Have you had any of the following symptoms since your injury? Please check the appropriate box:

☐ Aching	☐ Weakness	☐ Fatigue	☐ Radiating Pain
☐ Stress	☐ Blurred vision	☐ Discomfort	☐ Headaches
☐ Sharp pain	☐ Swelling	☐ Breathing difficulty	☐ Disorientation
☐ Shooting pain	☐ Tenderness	☐ Dizziness	☐ Muscle Spasms
☐ Sleep difficulty	☐ Throbbing Pain	☐ Coughing	☐ Dull pain
☐ Nausea	☐ Tightness	☐ Cracking noises	☐ Ear pain or ringing
☐ Numbness	☐ Soreness	☐ Tingling	☐ Cramping
☐ Stiffness	☐ Difficulty eliminating		

Symptoms are in the:

☐ Head ☐ Jaw ☐ Neck ☐ Wrists ☐ Hands

☐ Hips ☐ Thighs ☐ Legs ☐ Ankles ☐ Feet

☐ Chest ☐ Ribs ☐ Shoulders ☐ Buttocks ☐ Abdomen

Back: ☐ Upper ☐ Middle ☐ Lower

Symptoms are worsened by:

☐ Driving ☐ Exercise ☐ Lifting ☐ Bending

☐ Cold ☐ Heat ☐ Work ☐ Standing ☐ Sitting

☐ Twisting ☐ Walking ☐ Daily Activity

☐ Other ______________________________

Symptoms are eased by:

☐ Lying Down ☐ Resting ☐ Hot Packs ☐ Cold Packs

☐ Medication ☐ Massage ☐ Activity

☐ Other ______________________________

Medical History

Please check Yes or No to the following questions, and explain in spaces provided:

YES NO

☐ ☐ Are you under the care of a physician for any reason? Please explain: ____________________

____

☐ ☐ Are you taking any medications? If yes, when was your last dose? ________________________

☐ ☐ Any recent/current illnesses? ____

☐ ☐ Have you ever had surgery? If yes, please list. Include approximate date/year(s):

____

☐ ☐ Do you have any mobility needs that require additional assistance? ______________________

☐ ☐ Do you suffer from any of the following?

☐ Skin disorders or skin infections ____

☐ Allergies (☐ Oils, ☐ Nuts, ☐ Skin care ingredients, ☐ Other _______________________)

Have you ever been diagnosed with any of the following conditions? Please include approximate date of diagnosis, if applicable.

☐ Arthritis. Type and location ____

☐ High blood pressure ☐ Low blood pressure

☐ Aneurysm ☐ Embolism ☐ Deep Vein Thrombosis ☐ Compartment syndrome

☐ Heart Disease ☐ Other Cardiovascular Event ____

☐ Diabetes (☐ Type I, ☐ Type II - Adult Onset)

☐ Cancer. Type and location(s) ____

If yes, have you had lymph nodes removed? (Location: _______________________________________)

☐ Spinal condition (☐ Scoliosis, ☐ Osteoporosis, ☐ Other __________________________________)

☐ Other medical condition(s) ____

☐ Pregnant. If yes, how many weeks? ____

GENERAL UNDERSTANDING

I understand that Medical Massage Therapy and other related health care services from this office is not in any way to be used instead of or in place of consulting a Physician for diagnosis and treatment of any physical symptoms, but to be used in conjunction with or on the advice, referral, or prescription of my Physician(s). ________ Please initial.

CANCELLATION POLICY

Your scheduled appointments are reserved exclusively for you. Optima Clinic, LLC takes pride in our commitment to you in keeping all our appointments as scheduled. Please call as soon as you know you cannot make an appointment. All cancellations made after 5pm the business day before will be billed to you, the patient, for the time reserved. Your insurance company will not cover cancellation fees. Your courtesy and cooperation in enabling us to provide the best possible care for all of our physicians' patients is appreciated. ________ Please initial.

By my signature, I verify that all information provided on the previous 3 pages is true and correct to the best of my knowledge. I promise to keep my health care providers updated on any changes in my health and/or residence. I authorize payment of insurance benefits billed for services rendered by this office to be paid directly to this office for said services. I authorize this office to release any information in its possession requested by my insurance company to process claims.

____ ____________________

Patient (or Guardian's) Signature Date