Pacific Medical Group LLC

Rosalie J. Schreiber, NP

Primary Care Medicine

95 Lono Avenue, Suite 105

Kahului, HI 96732

Office: 808-873-0733

Fax: 808-873-9646

PATIENT INFORMATION

Date _____ Name _____

Sex _____ Marital Status _____ Date of Birth: _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Who referred you to our office? _____

Social Sec. # _____-_____-_____ Bus. Phone (_____) _____-_____ Employer _____

What is your preferred contact phone number? Home Cellular Work

May the office staff leave a message, for you at this number? Yes No

EMERGENCY CONTACT: Name _____ Phone _____

INSURANCE INFORMATION

Insurance Co._____ Phone # _____

Address_____ City _____ State _____ Zip _____

Date of Injury _____ Claim # _____

ADDITIONAL INSURANCE (Secondary Insurance)

Yes *No* If Yes Complete the following:

Name of insured _____ Relationship to Patient _____

Insurance Co. Name _____ Phone # _____

Insurance Co. Address_____ City_____ State____ Zip _____

Group # _____ Employer # _____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

MECHANISM OF INJURY

Please explain in detail how your accident happened: _____

_____

_____

_____

Are your work activities restricted as a result of this accident? *Yes* *No*

Since this injury are your symptoms *improving?* *getting worse?* *the same?*

Have you retained an attorney? *Yes* *No*

If so, name and address _____

Give date and time present injury occurred: **DATE** _____ 20_____ at _____ AM PM

Where did you feel pain immediately after the accident? _____

_____

Did you return to work? *Yes* *No* If so, date returned to work _____

CHIEF COMPLAINT

What Areas of your Body are in pain from this injury? Rate worst area, first and so on. (Please include any/all areas of numbness or radiating pain, tingling or other sensations from the injury as well)

1. Area _____ (circle) mild moderate severe
2. Area _____ (circle) mild moderate severe
3. Area _____ (circle) mild moderate severe
4. Area _____ (circle) mild moderate severe
5. Area _____ (circle) mild moderate severe
6. Area _____ (circle) mild moderate severe

Please **Circle** the Quality of the main area of pain: dull aching sharp shooting burning throbbing deep nagging other areas: _____

Does any of the areas of pain radiate or travel (shoot) to any areas of your body? *Yes* *No*

Where?_____

Do you have any numbness or tingling in your body? *Yes* *No*

Where? _____

Grade Intensity/Severity (0 is no pain) 0 1 2 3 4 5 6 7 8 9 10 (10 is worst possible pain)

How frequent is pain present, how long does it last? _____

Does anything aggravate it? _____

Does anything make it better? _____

LIMITATIONS TO ACTIVITIES OF DAILY LIVING DUE TO THIS INJURY

Do you have problems with self-care and personal hygiene? Yes No (circle those that apply)
brushing teeth, combing hair, bathing, dressing, eating, laundry, house work, yard work,
Do you have difficulty urinating and having bowel movements? Yes No How so? _____
_____

Do you have difficulty with communication? Yes No (circle those that apply)
writing, typing, seeing, hearing, speaking
Do you have difficulty performing certain physical activities? (circle those that apply) such as, standing, sitting, reclining, walking and climbing stairs
Do you have problems with, (circle those that apply) hearing, seeing, tasting, smelling
Do you have difficulty with such activities as (circle those that apply) grasping, lifting, walking, or weakness
Do you have problems traveling for prolonged periods either driving or flying? Yes No
Do you have difficulty sleeping and awakens with pain and discomfort? Yes No

TREATMENT

Who is your current treating Physician for this injury? _____

If so, give the doctor's name _____ *D.C., M.D., D.O., D.D.S.*

Doctor's Diagnosis _____

What treatments did you receive? _____

What Medications were prescribed? _____

Did you receive an X-ray or MRI? *Yes* *No* If yes, please bring the reports if available or what were the results?

_____

AUTO ACCIDENT SPECIFICS

What was your position in the vehicle? Driver's seat Front Passenger Rear Passenger Pedestrian

What type of vehicle were you driving ? _____

What speed were you traveling at the time of the accident? _____

Who hit who? Was struck by another vehicle Struck another vehicle Struck a stationary object

What was your vehicles point of impact? _____

What speed was the other vehicle traveling at the time of the accident? _____

What was the other vehicle's point of impact? _____

Were you wearing seat restraint's? Yes No

What position were your vehicle head rests in? Lowest Middle Highest

Did your vehicle air bags deploy? Yes No

Where you prepared for the impact? was completely surprised by the accident, saw the collision coming
saw the collision coming and braced appropriately

What position was your body in just prior to impact? _____

What happened to your body at impact? _____

What was your emotional state after the accident? _____

Did you receive medical attention at the scene of the accident? If so, what? _____

Where did you go immediately after the accident? (i.e. ER, doctor, home, work, etc.) _____

Did you hit any other body parts on parts of the vehicle at impact? If so, which? _____

_____

SOCIAL AND FAMILY HISTORY

FAMILY HEALTH HISTORY

Associated health problems of relatives:

_____

_____

Deaths in immediate family:

Cause of parents or siblings death Age at death

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

Do you smoke? *Yes* *No* Drink alcohol? *Yes* *No* (occasional socially daily) Recreational drugs? *Yes* *No*

If you smoke how many cigarettes per day? _____

RELEVANT MEDICAL HISTORY

Current illnesses: _____

_____

_____

Previous injury or trauma: _____

_____

_____

Have you ever broken any bones? *Yes* *No* Which? _____

List Allergies or Sensitivity to what medications:

_____

_____

CURRENT MEDICATIONS and DOSAGES

Medication & Dosage	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGURIES

Date	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with medical and other healthcare, in accordance with this state's statutes.

Signature _____ Date _____

If the patient is a minor (under I8 yrs. of age), please supply parent/guardian information below:

Name of Parent or Guardian _____

Home Phone_____ Cellular Phone_____

Address (if different than patient) _____ City_____ State_____ Zip Code_____

Parent/Guardian Signature _____ Date _____