STANGHERLIN CLINIC

8834 56th Street - Temple Terrace, FL 33617 - office (813) 983-1400- fax (813) 983-1441

INITIAL PATIENT QUESTIONNAIRE

Today's Date:___/___/___ SSN:____-___-_____ Age:_____ Sex: M / F

Your Name:_____ Birth date:___/___/___ Height:_____ Weight:_____

Home Address:_____
Street City State Zip

Phone: Home:_____ Cell:_____ Work:_____

Marital Status:_____ Occupation:_____ Employer:_____

Emergency Contact:_____ Phone:_____

HISTORY OF CONDITION

In your own words, what problems are you having that bring you to this office?

1._____

2._____

3._____

4._____

Current Medications:_____

Current Allergies:_____

Have you ever been diagnosed with any of the following?

__Diabetes __Heart Disease __High Blood Pressure __Cancer	__Asthma __Tuberculosis __Herpes __HIV/AIDS	__Depression __Mental Disorder __Liver Problems __Vascular Disease	__Mumps __Measles __Chicken Pox __Polio

HISTORY CONTINUED

List any surgeries you have had:_____

Have you ever been hospitalized:_____

Have you had any previous injuries/ accidents? Please list dates and treatment if any:

_____

Do you have a family history of chronic illness?_____

_____ _____
Patient Signature Date

Please do not write below this line. Proceed to the next page.

Insured's Name:_____ Relationship:_____

Insurance Company:_____

Address:_____ City:_____ ST____ ZIP_____

Phone:_____ Ext_____ Fax:_____

Claim #:_____ Policy #:_____

Adjustor:_____ Date Called:_____

_____Group _____ Cash _____Private _____ W/C _____PIP _____LOP _____Other

Deductible:_____ Met:_____ Coverage:_____ Medpay:_____

Additional information:_____

Attorney Name:_____ Phone:_____

Address:_____

Additional Notes:_____
_____
_____
_____
_____
_____

HISTORY OF ACCIDENT

Date of Accident: ___/___/___ Time of Accident:_____ AM/ PM

Where were you seated: Driver/ Passenger/ Front/ Rear _____

Make/ Model of vehicle you were occupying:_____

Location where the accident occurred:_____

Approximately how fast were you traveling when the accident occurred? _____MPH.

Make/ Model of other vehicle(s) involved:_____

In you own words, briefly describe the accident: _____

_____

_____

_____

_____

At the time of the accident, which way were you facing? Forward? Turned?_____

Were you surprised by the accident? **Y / N** Were you wearing a seatbelt? **Y / N**

Did the airbags deploy? **Y/ N** Were you rendered unconscious? **Y/ N**

Were the police notified? **Y/ N** Was a report filed? **Y / N** With who?_____

How did you feel immediately following the accident?_____

Is the pain: _____Getting better _____No Improvement _____Getting Worse

Did you go to the hospital? **Y / N** Where:_____ How:_____

Were X-rays/ CT / MRI performed? **Y/ N** Which?_____

Were you prescribed medication? **Y / N** Which?_____

Have you seen another doctor for this injury? **Y / N** Who?_____

Have you been able to work since the accident? **Y / N** Why?_____

What could you do before the accident that you are now unable to do?_____

Do you have an attorney? Y/ N Who?_____

_____ _____

Patient Signature Date