SYNERGY HEALTH PARTNERS

PATIENT NAME: _____
TODAY'S DATE: _____
DATE OF LOSS: _____

Premise Liability or Pedestrian vs Auto

PATIENT PERSONAL INFORMATION

LAST NAME:		**FIRST NAME:**		**MIDDLE INITIAL:**
DATE OF BIRTH:		**AGE:**	**SOCIAL SECURITY NUMBER:**	
ADDRESS:		**CITY:**	**STATE:**	**ZIP:**
HOME PHONE:	**MOBILE PHONE:**	**WORK PHONE:**	**MAY WE LEAVE A VOICE MAIL AT THESE NUMBERS?** ☐ Yes ☐ No	
E-MAIL ADDRESS:		**HEIGHT:**	**WEIGHT:**	
MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed		**HAND DOMINANCE:** ☐ Right ☐ Left	**GENDER:** ☐ M ☐ F	

EMERGENCY CONTACT INFORMATION

FULL NAME:	**RELATIONSHIP TO YOU:**
PHONE:	**MAY WE LEAVE A VOICE MAIL AT THIS NUMBER?** ☐ Yes ☐ No

INSURANCE INFORMATION

(Please list the following information on the vehicle you were in at the time of the collision.)

PERSON AT FAULT: ☐ Self ☐ Other **Name:** ☐ CASE # ONLY PROVIDED	**PERSON AT FAULT INSURANCE COMPANY (IF KNOWN):**	
AT FAULT AUTO INSURANCE PHONE:	**AT FAULT POLICY NUMBER:**	**AT FAULT CLAIM NUMBER:**
DO YOU HAVE PERSONAL MEDICAL INSURANCE? ☐ Yes ☐ No	**NAME OF MEDICAL INSURANCE:**	

ATTORNEY INFORMATION ☐ None at this time

FULL NAME:	**NAME OF LAW FIRM:**		
ATTORNEY'S ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
ATTORNEY'S PHONE:	**ATTORNEY'S FAX:**	**PARALEGAL HANDLING CASE (IF KNOWN):**	

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: _____

DATE OF LOSS: _____

INCIDENT INFORMATION FOR PREMISE LIABILITY

DATE OF EVENT	**TIME OF EVENT**	**LOCATION OF EVENT**
DO YOU KNOW IF THERE IS A VIDEOTAPE OF THE INCIDENT?	☐ **Yes** ☐ **No**	
HAS THE INSURANCE CARRIER CONTACTED YOU?	☐ **Yes** ☐ **No**	
DID ANYONE WITNESS THE FALL?	☐ **Yes** ☐ **No**	
DID THEY GIVE A WRITTEN STATEMENT?	☐ **Yes** ☐ **No**	
DO YOU HAVE A NAME AND NUMBER?	☐ **Yes** ☐ **No If so please list them below**	
EXPLAIN BRIEFLY HOW YOUR INCIDENT OCCURED:		
AT THE TIME OF THE INCIDENT, YOU WERE LOOKING:	☐ Forward ☐ Right ☐ Left ☐ Backward	
DO YOU THINK YOU LOST CONSCIOUSNESS? ☐Yes☐No If Yes, How Long? _____ ☐ Sec. ☐Min. ☐Hours	**WERE YOU:** ☐ Shaken ☐Disoriented ☐Dazed If Yes, How Long? ____ ☐ Sec. ☐ Min. ☐ Hours	
DID YOU RECEIVE ANY: ☐ Bruises ☐ Cuts/Lacerations/Abrasions: **If so Please list below:**		

INCIDENT INFORMATION FOR PEDESTRIAN VS. AUTO

DATE OF INCIDENT:		**TIME OF INCIDENT:**		**WERE YOU A:**	☐ Pedestrian ☐ Cyclist
SPEED OF THE VEHICLE IMPACT:	` **MPH**	**WHERE WAS THE IMPACT TO YOUR BODY/BIKE?**		☐ Front ☐ Left Side ☐ Back ☐ Right Side	
TYPE OF VEHICLE INVOLVED:	**YEAR:**	**MAKE:**		**MODEL:**	
NAME OF THE STREET YOU WERE ON:		**NAME OF THE STREET THE NEAREST CROSS STREET:**			
WERE YOU: ☐ Walking ☐ Crossing the Street ☐ On the Sidewalk ☐ Riding in the Street ☐ On the job					
EXPLAIN BRIEFLEY HOW YOUR INCIDENT OCCURED:					
DID YOU RECEIVE ANY: ☐ Bruises ☐ Cuts/Lacerations/Abrasions **If so Please list below. N/A** ☐					
DID YOU HIT YOUR HEAD? ☐ **Yes** ☐ **No** **IF YES, WHERE?**		**DO YOU THINK YOU LOST CONSCIOUSNESS?** ☐ Yes ☐ No If Yes, How Long? _____ ☐ Sec. ☐ Min. ☐ Hrs			
WERE YOU: ☐ Shaken ☐ Disoriented ☐ Dazed If Yes, How Long? _____ ☐ Sec ☐ Min ☐ Hours		**DID THE POLICE COME TO THE SCENE?** ☐ **Yes** ☐ **No** **DEPARTMENT:**		**DO YOU HAVE A POLICE REPORT/ CASE NUMBER? C#**	

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: _____

DATE OF LOSS: _____

TREATMENT RECEIVED AFTER THIS COLLISION

WERE YOU TREATED ON THE SCENE BY PARAMEDICS?
☐ Yes ☐ No

DID YOU GO TO THE EMERGENCY ROOM, HOSPITAL, OR URGENT CARE? ☐ Yes ☐ No (Please indicate below which hospital)

IF "YES", WHEN DID YOU GO?
☐ Day of the collision ☐ Other Date: _____

IF THE DAY OF THE COLLISION, HOW DID YOU GET THERE?
☐ Ambulance ☐ Self ☐ Other:

Hospital/Provider	Date	Hospital/ Provider	Date	Hospital/ Provider	Date
☐ Children's Hospital	_____	☐ Medical Center of Aurora	_____	☐ St. Anthony's Central	_____
☐ Denver Health	_____	☐ North Suburban Medical	_____	☐ St. Joseph's Hospital	_____
☐ Good Samaritan	_____	☐ Porter Adventist	_____	☐ Swedish Medical Center	_____
☐ Kaiser Permanente	_____	☐ Rose Medical Center	_____	☐ University Hospital	_____
☐ Littleton Adventist	_____	☐ St. Anthony North	_____	☐ Sky Ridge Medical	_____
☐ Lutheran Med. Cent	_____	☐ Other _____	_____	☐ N/A	

WHERE HAVE YOU GONE FOR ADDITIONAL TREATMENT SINCE THE COLLISION? N/A ☐ (CHECK ALL THAT APPLY)

Primary Care Doctor:		**Start Date**		**Number of visits:**	
Physical Therapy:		**Start Date:**		**Number of Visits:**	
Chiropractic:		**Start Date:**		**Number of Visits:**	
Specialist:		**Start Date:**		**Number of Visits:**	
Surgery:		**Date:**		**Location:**	

WHICH OF THE FOLLOWING DIAGNOSTIC TESTS HAVE YOU HAD FOR THIS COLLISION?N/A ☐

	FACILITY	BODY PART	DATE	KNOWN RESULTS
☐ X-RAY	_____	_____	_____	_____
☐ CT Scan	_____	_____	_____	_____
☐ MRI	_____	_____	_____	_____
☐ Ultrasound	_____	_____	_____	_____

☐ Other_____

DID YOU HAVE A GAP/BREAK IN CARE FOR THIS COLLISION (I.E. DID NOT SEE A HEALTH CARE PROVIDER WITHIN THE FIRST FEW DAYS OR HAD A BREAK IN CARE AGAIN FOR 2 WEEKS OR MORE)?

☐ Yes ☐ No

IF "YES" TO ANY OF THE ABOVE, PLEASE CHECK THE REASON(S) FROM THE FOLLOWING LIST:

☐ I thought I would get better with time or assumed I could treat myself at home.

☐ I could not afford to pay out-of-pocket expenses for needed care.

☐ I was out of town and unable to find a provider in that area.

☐ I was afraid I would lose my job.

☐ Had to make and wait for the appointment.

☐ Other:_____

☐ I have no health insurance.

☐ I ran out of health insurance benefits.

☐ I was refused treatment at the doctor's office as it was auto insurance.

☐ Insurance Company problems over treatment and/or payment.

☐ Unsure on what to do or where to go for help.

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: _____

DATE OF LOSS: _____

EMOTIONAL/BEHAVIORAL CHANGES ☐ TOO SOON TO TELL ☐ NO BEHAVIORAL CHANGES

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- ☐ Depression / Sadness
- ☐ Nightmares About Accident
- ☐ Irritable/Angry
- ☐ Discouraged / Frustrated
- ☐ Nervous/ Worried
- ☐ Appetite Changes (Loss / Gain)
- ☐ Feeling Tired All the Time
- ☐ Driving Anxiety
- ☐ Other: _____

At any time during the event, did you think you might die or not survive? ☐ Yes ☐ No

I stay away from the things that remind me of the event? ☐ Yes ☐ No

Sometimes images from the event pop into my mind even when I am not thinking about it? ☐ Yes ☐ No

COGNITIVE CHANGES ☐ TOO SOON TO TELL ☐ NO COGNITIVE CHANGES

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

- ☐ Forgetful
- ☐ Lack of Concentration
- ☐ Difficulty Understanding words or instructions
- ☐ Memory Loss
- ☐ Difficulty Problem Solving
- ☐ Slow in Thinking/Acting/Speaking
- ☐ Trouble Finding Words
- ☐ Getting Lost or Confused
- ☐ Problems Thinking

WHAT INCREASES YOUR PAIN? (CHECK ALL THAT APPLY) ☐ TOO SOON TO TELL ☐ NOTHING MAKES IT WORSE

- ☐ Sitting
- ☐ Standing
- ☐ Bending
- ☐ Stress or Tension
- ☐ Other: _____
- ☐ Lifting
- ☐ Walking
- ☐ Work
- ☐ Coughing or Sneezing
- ☐ Lying Down
- ☐ Grasping
- ☐ Reaching
- ☐ Weather Changes

WHAT DECREASES YOUR PAIN? (CHECK ALL THAT APPLY) ☐ TOO SOON TO TELL ☐ NOTHING MAKES IT BETTER

- ☐ Rest
- ☐ Ice
- ☐ Physical Therapy
- ☐ Sitting
- ☐ Other: _____
- ☐ Medications
- ☐ Stretching
- ☐ Chiropractic
- ☐ Standing
- ☐ Heat
- ☐ Exercise
- ☐ Massage
- ☐ Lying Down

ACTIVITIES OF DAILY LIVING / FUNCTIONAL STATUS

(These questions are about how your symptoms/injuries affect your activities now. Check **ALL** the activities that have been limited in the last 4 weeks due to your injuries/collision.)

BASIC SELF-CARE / ACTIVITIES OF DAILY LIVING: ☐ TOO SOON TO TELL ☐ NOTHING IS AFFECTED

- ☐ Bathing / Showering
- ☐ Brushing Teeth
- ☐ Dressing
- ☐ Combing Hair
- ☐ Eating
- ☐ Sexual Activity

COMPLEX SELF-CARE AND HOUSEHOLD DUTIES: ☐ TOO SOON TO TELL ☐ NOTHING IS AFFECTED

- ☐ Meal Preparation
- ☐ Cleaning
- ☐ Financial Management
- ☐ Vacuuming
- ☐ Sweeping / Mopping
- ☐ Other: _____
- ☐ Yard Work
- ☐ Managing Medications

BASIC MOBILITY: ☐ TOO SOON TO TELL ☐ NOTHING IS AFFECTED

- ☐ Walking
- ☐ Running
- ☐ Grasping
- ☐ Squatting / Stooping
- ☐ Pushing
- ☐ Reaching
- ☐ Bending
- ☐ Sit-to-Stand
- ☐ Lifting Above Shoulder
- ☐ Lying Down
- ☐ Climbing Stairs
- ☐ Getting Up from lying down
- ☐ Driving/Riding
- ☐ Kneeling
- ☐ Lifting from Floor
- ☐ Pulling
- ☐ Moving Neck
- ☐ Other: _____

BASIC COMMUNICATION: ☐ TOO SOON TO TELL ☐ NOTHING IS AFFECTED

- ☐ Hearing
- ☐ Writing
- ☐ Speaking
- ☐ Typing
- ☐ Computer Use
- ☐ Texting

CHILDCARE ACTIVITIES: (☐ N/A, I Do Not Have Small Children)

- ☐ Lifting/Holding
- ☐ Changing Diapers
- ☐ Other: _____
- ☐ Dressing Child
- ☐ Bathing Child
- ☐ Helping w/Homework
- ☐ Car Seat Management

Number of Children: _____ **Age(s) of Children:** _____

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: _____

DATE OF LOSS: _____

DO YOU HAVE PROBLEMS SLEEPING DUE TO YOUR PAIN?

☐ Yes ☐ No

HOW MANY HOURS OF RESTFUL SLEEP DO YOU GET PER NIGHT? _____

DO YOU SLEEP TOO MUCH?

☐ Yes ☐ No

HOW MANY TIMES PER NIGHT DO YOU WAKE UP WITH PAIN? _____

ARE THERE ANY HOBBIES OR RECREATIONAL ACTIVITIES YOU COULD DO PREVIOUSLY THAT YOU CANNOT DO NOW?

☐ Yes ☐ No If "Yes", what activities: _____

MEDICAL HISTORY/ REVIEW OF SYSTEMS

CHECK ALL CURRENT AND/OR PAST MEDICAL CONDITIONS (Not related to this collision): N/A ☐

	CURRENT	PAST		CURRENT	PAST
HIGH BLOOD PRESSURE	☐	☐	BLOOD/ANEMIA/BRUISING	☐	☐
HEAD/ HEADACHES	☐	☐	BONES/ JOINTS	☐	☐
HEART DISEASE/ CIRCULATION	☐	☐	EYES/VISION/CATARACTS	☐	☐
DEPRESSION/ANXIETY/BIPOLAR	☐	☐	DIABETES	☐	☐
COPD/LUNGS/ASTHMA	☐	☐	KIDNEY DISEASE	☐	☐
THYROID DISEASE	☐	☐	OSTEOPOROSIS	☐	☐
SLEEP APNEA/SLEEPING	☐	☐	PREGNANCY	☐	☐
HIGH CHOLESTEROL	☐	☐	CANCER	☐	☐
AIDS/HIV POSITIVE	☐	☐	STOMACH/BOWELS	☐	☐
LIVER DISEASE	☐	☐	FEMALE PARTS	☐	☐
SEIZURES/EPILEPSY	☐	☐	MALE PARTS	☐	☐
EARS/HEARING	☐	☐	BRAIN(Stroke, Dementia, Alzheimer's/other Memory issues)	☐	☐
OTHER:_____			CONCUSSION/TRAUMATIC BRAIN INJURY How many?_____	☐	☐

HAVE YOU EVER HAD ANY SURGERIES/HOSPITALIZATIONS? ☐ Yes ☐ No If "Yes", please list:

TYPE OF SURGERY / WHY HOSPITALIZED	YEAR	FULLY RECOVERED?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

EVER BEEN IN AN AUTO COLLISION BEFORE?

☐ Yes ☐ No

IF "YES", HOW MANY? _____

WHEN? _____

ALL CLAIMS CLOSED? ☐ Yes ☐ No

IF NO, WHICH CLAIMS ARE OPEN? _____

DID YOU COMPLETELY RECOVER? ☐ Yes ☐ No

IF YOU DID NOT COMPLETELY RECOVER, WHAT ARE THE RESIDUAL COMPLAINTS? (☐ **N/A)**

EVER HAD A WORK-RELATED INJURY?

☐ Yes ☐ No

IF "YES", HOW MANY? _____

WHEN? _____

ALL CLAIMS CLOSED? ☐ Yes ☐ No

IF NO, WHICH CLAIMS ARE OPEN? _____

DID YOU COMPLETELY RECOVER? ☐ Yes ☐ No

IF YOU DID NOT COMPLETELY RECOVER, WHAT ARE THE RESIDUAL COMPLAINTS?(☐ **N/A)**

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: _____

DATE OF LOSS: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No
If "Yes", Explain: _____

ARE YOU ALLERGIC TO LATEX? ☐ Yes ☐ No

ARE YOU ALLERGIC TO MEDICAL TAPES? ☐ Yes ☐ No

DO YOU USE THE FOLLOWING? ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair **IF SO, HOW LONG?**_____

MEDICATIONS

Please list **ALL PRESCRIPTION** medications that you are **CURRENTLY** taking: **N/A** ☐

MEDICATION	DOSE	HOW OFTEN?	WHEN STARTED?	WHY?

Please list **ALL OVER-THE-COUNTER** medications that you are **CURRENTLY** taking: **N/A** ☐

MEDICATION	DOSE	HOW OFTEN?	WHEN STARTED?	WHY?

FAMILY MEDICAL HISTORY (Examples: Diabetes, High Blood Pressure, Cancer, etc.)

Mother: _____ ☐ NONE
Father: _____ ☐ NONE
Siblings/ Other Relatives: _____ ☐ NONE

OCCUPATION / WORK HISTORY

(The purpose of this section is to understand how your injuries have affected your work.) ☐ UNEMPLOYED ☐ RETIRED ☐ STUDENT

CURRENT EMPLOYER:	JOB TITLE / OCCUPATION:
JOB DUTIES AND RESPONSIBILITIES:	

WHAT ARE THE PHYSICAL REQUIREMENTS OF YOUR JOB? (CHECK ALL THAT APPLY)

☐ Sitting ☐ Standing ☐ Typing ☐ Bending
☐ Squatting ☐ Kneeling ☐ Climbing (Ladders, etc.) ☐ Lifting (_____ lbs.)

HAVE YOU MISSED ANY TIME FROM WORK DUE TO THIS COLLISION? ☐ Yes ☐ No ☐ I have not returned to work

IF YES, HOW MANY HOURS OR DAYS HAVE YOU MISSED? _____

ARE YOU CURRENTLY WORKING? ☐ Normal Hours ☐ Decreased Hours

ARE YOU MODIFYING YOUR HOURS OR DUTIES? (CHECK ALL THAT APPLY): ☐ Normal Job Duties ☐ Modified Job Duties ☐ Different Jobs

If you are working a different job since the collision, please explain: _____

INITIALS: _____

SYNERGY HEALTH PARTNERS

PATIENT NAME: _____

TODAY'S DATE: _____

DATE OF LOSS: _____

SOCIAL HISTORY

DO YOU SMOKE/USE TOBACCO? ☐ Yes ☐ No

IF "YES", HOW OFTEN? _____ / ☐ Day ☐ Week ☐ Month

DO YOU DRINK ALCOHOL? ☐ Yes ☐ No

IF "YES", HOW OFTEN? _____ ☐ Day ☐ Week ☐ Month

DO YOU USE ILLEGAL DRUGS?
☐ **Yes** ☐ **No**

WHAT IS THE HIGHEST EDUCATION LEVEL YOU HAVE COMPLETED?
☐ Elementary ☐ High School ☐ Vocational ☐ Some College ☐ College Degree ☐ Advanced Degree
☐ Other: _____

PATIENT AFFIRMATION: ***By signing below, you confirm that the information you provided is accurate to the best of your knowledge.***

Patient's Signature: _____ **Date:** _____

Parent / Guardian Signature ***(If patient is a minor):*** _____ **Date:** _____

Photo Permission: ***I give my permission to take my photo for the purposes of chart identification and, if necessary, to document portions of the physical exam.***

Patient's Signature: _____ **Date:** _____

If filled out by a person other than the patient, please provide name and signature below.

Printed Name: _____ **Signature:** _____

INITIALS: _____