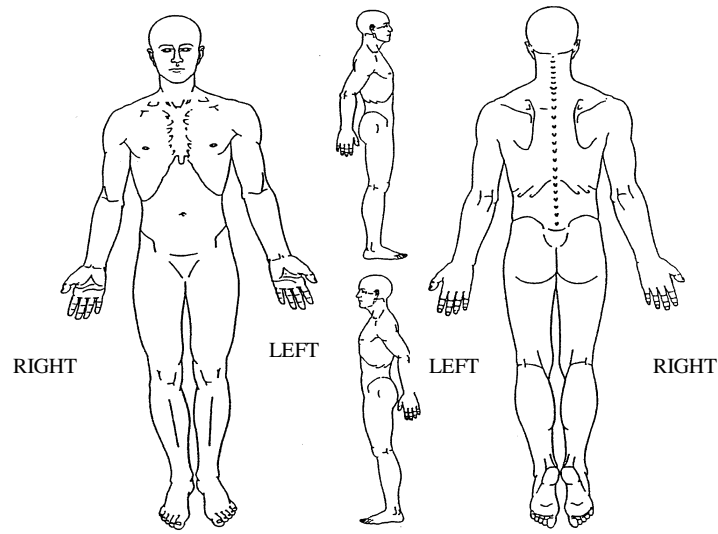


**Briefly describe your problem(s):** \_\_\_\_\_

**Draw or mark on the picture where you feel pain.**  
 You may write on the picture using words that describe your pain such as: Aches, sore, burning, tingling, numbness, sharp pain, shooting pain, etc.



Describe your complaints below:

**Head or Jaw:** \_\_\_\_\_

\_\_\_\_\_

**Neck:** \_\_\_\_\_

\_\_\_\_\_

**Shoulders, arms, hands:** \_\_\_\_\_

\_\_\_\_\_

**Mid Back, Chest, Abdomen:** \_\_\_\_\_

\_\_\_\_\_

**Low back:** \_\_\_\_\_

\_\_\_\_\_

**Hips, legs, knees, feet:** \_\_\_\_\_

\_\_\_\_\_

**Other:** \_\_\_\_\_

**Check** the activities below that are difficult or painful to do:

- |   |                                   |                                    |   |
|---|-----------------------------------|------------------------------------|---|
| <input type="checkbox"/> Hearing          | <input type="checkbox"/> Dressing | <input type="checkbox"/> Squatting | <input type="checkbox"/> Sitting          |
| <input type="checkbox"/> Seeing           | <input type="checkbox"/> Typing   | <input type="checkbox"/> Climbing  | <input type="checkbox"/> Driving          |
| <input type="checkbox"/> Reading          | <input type="checkbox"/> Writing  | <input type="checkbox"/> Kneeling  | <input type="checkbox"/> Riding in car    |
| <input type="checkbox"/> Tasting          | <input type="checkbox"/> Grasping | <input type="checkbox"/> Bending   | <input type="checkbox"/> Plane travel     |
| <input type="checkbox"/> Smelling         | <input type="checkbox"/> Holding  | <input type="checkbox"/> Twisting  | <input type="checkbox"/> Sports           |
| <input type="checkbox"/> Eating           | <input type="checkbox"/> Pinching | <input type="checkbox"/> Carrying  | <input type="checkbox"/> Exercising       |
| <input type="checkbox"/> Using the phone  | <input type="checkbox"/> Standing | <input type="checkbox"/> Lifting   | <input type="checkbox"/> Sexual Activity  |
| <input type="checkbox"/> Bathing          | <input type="checkbox"/> Leaning  | <input type="checkbox"/> Pushing   | <input type="checkbox"/> Reclining        |
| <input type="checkbox"/> Grooming         | <input type="checkbox"/> Walking  | <input type="checkbox"/> Pulling   | <input type="checkbox"/> Restful Sleeping |
| <input type="checkbox"/> Using the toilet | <input type="checkbox"/> Stooping | <input type="checkbox"/> Reaching  |   |

Other \_\_\_\_\_

Please tell the doctor about any other concerns not listed above. Welcome to Hopkins Clinic!

**Hopkins Clinic**  
**Confidential Patient Information**

6231 66<sup>th</sup> Street North, Pinellas Park, FL 33781 T - (727) 544 3330 F - (727) 544 3221

**AUTOMOBILE ACCIDENT QUESTIONNAIRE**

If the purpose of your visit today is related to injury sustained in an automobile accident, please answer the following questions. Please feel free to ask for help if you do not understand any of these questions.

Name: \_\_\_\_\_

Date of accident? \_\_\_\_\_ Location of accident (City/State) \_\_\_\_\_

Briefly describe how the accident occurred: \_\_\_\_\_

\_\_\_\_\_

Were you the driver? YES\_\_\_ NO\_\_\_ If a passenger, were you in the front or back seat? \_\_\_\_\_

Were you wearing your seatbelt? YES\_\_\_ NO\_\_\_ Did the airbags deploy? YES\_\_\_ NO\_\_\_

Did you know the crash was about to happen? YES\_\_\_ NO\_\_\_ Did you brace for the impact? YES\_\_\_ NO\_\_\_

Did you get cut or scraped anywhere? YES\_\_\_ NO\_\_\_ Describe \_\_\_\_\_

Did you get bruised anywhere? YES\_\_\_ NO\_\_\_ Describe \_\_\_\_\_

Did you have any immediate pain? YES\_\_\_ NO\_\_\_ Describe \_\_\_\_\_

\_\_\_\_\_

Did you hit your head? YES\_\_\_ NO\_\_\_ Did you lose consciousness? YES\_\_\_ NO\_\_\_

Did the police investigate the accident? YES\_\_\_ NO\_\_\_ Did an ambulance arrive? YES\_\_\_ NO\_\_\_

Did you go to the hospital by ambulance? YES\_\_\_ NO\_\_\_ What hospital? \_\_\_\_\_

Were you transported on a backboard YES\_\_\_ NO\_\_\_ with a neck collar in place? YES\_\_\_ NO\_\_\_

At the hospital, were you examined? YES\_\_\_ NO\_\_\_ Were x-rays taken? YES\_\_\_ NO\_\_\_

Was a CT scan performed? YES\_\_\_ NO\_\_\_ Was any laboratory work performed? YES\_\_\_ NO\_\_\_

Were you given prescriptions? YES\_\_\_ NO\_\_\_ for what? \_\_\_\_\_

Were you admitted to the hospital YES\_\_\_ NO\_\_\_ or released to see your own doctor? YES\_\_\_ NO\_\_\_

Were you referred to any other doctor? YES\_\_\_ NO\_\_\_ Who? \_\_\_\_\_

Have you been examined or treated by any other physician since the accident? YES\_\_\_ NO\_\_\_

Who? \_\_\_\_\_

What treatments have you received? \_\_\_\_\_

Please **circle** the areas that you are currently having pain and at this time:

head jaw neck mid back lower back chest abdomen pelvis

shoulder arm elbow forearm wrist hand hip thigh knee lower leg ankle foot

Are you experiencing any numbness or tingling in the ? arms hands legs feet

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Please list any other symptoms you are experiencing: \_\_\_\_\_

Welcome to **HOPKINS CLINIC**. **Help us help you by completing this form. Please answer all the questions completely. All information provided is strictly confidential.** If you do not understand a question or are unsure of the information, please ask for assistance.

**HEALTH HISTORY FORM**

Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have a **Primary Care Doctor**? Dr. \_\_\_\_\_ Phone? \_\_\_\_\_

*May we request and / or send information to the above-mentioned healthcare providers in order to make them aware of your progress and keep your records updated?* **NO** \_\_\_ **YES** \_\_\_

**Have you had or now have:**

- |                   |                    |                     |                    |                   |
|-------------------|--------------------|---------------------|--------------------|-------------------|
| chronic fatigue__ | stroke__           | gas problems__      | osteo arthritis__  | numbness__        |
| visual problems__ | vascular disease__ | vomiting__          | rheumatoid arth.__ | tingling__        |
| sinusitis__       | swollen ankles__   | constipation__      | gout__             | depression__      |
| ear aches__       | asthma__           | diarrhea__          | swollen joints__   | anxiety__         |
| pain swallowing__ | emphysema__        | rectal bleeding__   | rashes__           | bipolar__         |
| headaches__       | short of breath__  | liver disease__     | psoriasis__        | diabetes__        |
| migraines__       | lung problems__    | kidney disease__    | bruise easily__    | thyroid problem__ |
| heart disease__   | tuberculosis__     | bladder problem__   | melanoma__         | anemia__          |
| chest pain__      | ulcers__           | menstrual problem__ | cancer__           | allergies__       |
| hypertension__    | stomach pain__     | prostate problem__  | epilepsy__         | immune problem__  |

\_\_\_\_ **NONE OF THE ABOVE**

**MEDICAL ALLERGIES?** (Penicillin, sulfur, etc?) **No / Yes** (Please list) \_\_\_\_\_

**Food or environmental allergies?** \_\_\_\_\_

Are you regularly taking **over the counter** medications? \_\_\_**No** \_\_\_**Yes** **Please circle:** Vitamins Aspirin Tylenol Advil Aleve Antacids Laxative Allergy Sleep-aids Other: \_\_\_\_\_

Are you taking **Cortico-Steroids**? **No** \_\_\_ **Yes** \_\_\_ For what condition? \_\_\_\_\_

Are you regularly taking **prescription medications**? **No** \_\_\_ **Yes** \_\_\_ **For what condition?**

- |               |                  |                 |                  |             |
|---------------|------------------|-----------------|------------------|-------------|
| Allergy__     | Birth control__  | Depression__    | Immune system__  | Headaches__ |
| Antibiotics__ | Blood Pressure__ | Diabetes__      | Kidney problem__ | Migraines__ |
| Anxiety__     | Cholesterol__    | Heart Disease__ | Osteoporosis__   | Clotting__  |
| Asthma__      | Chronic Pain__   | Hormones__      | Indigestion__    | Epilepsy__  |

**Please list names and dosage of medications:** \_\_\_\_\_

Do you have any **intolerances or side effects** from any medications such as gas, nausea, gastritis, constipation, hives, etc.)? \_\_\_**None** \_\_\_\_\_

List any **SURGERIES** and the date of the surgery. \_\_\_**None** \_\_\_\_\_

List **broken bones**? **None** \_\_\_ **Yes** \_\_\_ What and when? \_\_\_\_\_

Any **serious illnesses**? **No / Yes** If yes, what and when? \_\_\_\_\_

Please list any **hospitalizations**, for what reason and what year: None

List any previous **car** or **work related accident / injury**? No Yes... If yes, give date and briefly describe:

Are you?...Single Married Separated Divorced Widowed

If **employed**, briefly describe your **occupation**: \_\_\_\_\_

Are you exposed to any **hazardous substances**? **Yes / No** List: \_\_\_\_\_

Do you perform any **heavy lifting**? **Yes / No** Describe: \_\_\_\_\_

If no longer working, **when and why did you stop**? \_\_\_\_\_

Do you use **tobacco**? Yes\_\_\_ No\_\_\_ Cigarettes: \_\_\_pack per day for \_\_\_ years; Other \_\_\_\_\_

Do you drink **alcohol**? Yes\_\_\_ No\_\_\_ Daily\_\_\_ Weekly\_\_\_ Socially\_\_\_ Rarely\_\_\_

Do you drink **coffee**? Yes\_\_\_ No\_\_\_ Cups per day \_\_\_\_\_ Drink **cola**? Yes\_\_\_ No\_\_\_ Cans per day \_\_\_\_\_

Please list **pregnancies**: None

Year of birth	Sex of birth	Complications if any

**Please list any diseases or cause of death for the following family members:**

Relation	Age	State of health	Age at death	Cause of death	Check (✓) if your blood relatives had any of the following diseases (relationship to you)
<b>Father</b>					<input type="checkbox"/> arthritis, gout
<b>Mother</b>					<input type="checkbox"/> asthma, emphysema
<b>Brothers</b>					<input type="checkbox"/> cancer
					<input type="checkbox"/> chemical dependency
					<input type="checkbox"/> diabetes
<b>Sisters</b>					<input type="checkbox"/> heart disease, stroke, high blood pressure
					<input type="checkbox"/> kidney disease
					<input type="checkbox"/> tuberculosis

**Please tell the doctor about any other concerns not listed above. Use the space below to write about any other concerns you may have. Thank you and Welcome to Hopkins Clinic!**