# LAROCCA INJURY CENTERS

2718 Letap Court Unit 102
Land o' Lakes, FL 34638
P: (727) 797-7090
*Partner Office*

2017 Drew St.
Clearwater, FL 33765
P: (727) 797-7090

5058 66th St. N.
St. Petersburg, FL 33709
P: (727) 797-7090

3306 us 19 #B
Holiday, FL 34691
P: (727) 312-5190

3908 9th Ave W
Bradenton, FL 34205
P:(941) 714-0714

1401 E Bay Dr,
Largo, FL 33771
P:(727) 501-0081

4204 N. MacDill Ave. B
Tampa, FL 33706
P: (813)898-8888

11401 N. 56th St. Ste. 18
Temple Terrace, FL 33617
P: (727) 797-7090
*Partner Office*

711 N Lake Parker Ave
Lakeland, FL 33801
P: 863-603-8797

3301-5th Ave. S.
St. Petersburg, FL 33712
P: (727) 328-0000
*Partner Office*

325 South Parsons Ave
Brandon, FL 33511
P: (727) 797-7090

## Patient Information:

Today's Date _____

Patient Full Name _____

Address_____ Apt # _____

City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address_____

Date of Birth _____ Age_____ Marital Status_____ Male____ Female____

Social Security #_____ -_____ -_____

Insurance Company _____Policy#_____

Claim #:_____

## Injury Description:

Date of Injury/Accident_____

Where Injury/Accident happened (i.e., street, store, or building)_____

City_____ State_____

Were you the: [] Driver or [] Passenger. Were you sitting in the: [] Front Seat or [] Back Seat

Impact was on: [] Behind [] Front [] Left Side [] Right Side

Did the airbags deploy? [] Yes [] No

Were there any other passengers in the car? [] Yes [] No

Was your vehicle stopped when the accident happened? [] Yes [] No

## Hospital:

Did you go to the hospital? [] Yes [] No If yes; which hospital? _____

When did you go? [] Immediately [] Same Day [] Next Day [] Other _____

How did you get there? [] Ambulance [] Self [] Someone else took me

**Patient Signature: _____ Date: _____**

**Hospital Continued:**

What type of treatment was given at the hospital?

_____

_____

Were you examined? [] Yes [] No

Were x-rays taken? [] Yes [] No

Did you have a MRI? [] Yes [] No

Were you given any prescriptions? [] Yes [] No

If yes; what type of medications?_____

Did you see another doctor OTHER than at the hospital? [] Yes [] No

Doctor's Name: _____ Phone: _____ Fax: _____

What treatment did you receive from the OTHER doctor? [] Medications [] Physical therapy [] X-Rays [] MRI

Other? _____

How often do you see the doctor or receive physical therapy?_____

## Details of Your injuries:

Did you strike any part of your body on any part of the car? [] Yes [] No [] I don't remember

If yes; please describe:_____

_____

**Circle Injury Areas From This Accident:** *circle all that apply*:

| | | | | | | |
|---|---|---|---|---|---|---|
| Head | Jaw | Neck | Upper Back | Shoulders | Arms | Hands |
| Mid back | Low back | Hips | Legs | Knees | Feet | |

Any cuts or scrapes resulting from accident? [] Yes [] No If yes; where? _____

_____

Any bruises resulting from accident? [] Yes [] No If yes; where? _____

_____

**Social & Work History:**

What is your occupation? _____

What are your physical requirements on the job?_____

Have you lost any time at work? [] Yes [] No If yes, how much time? Days_____ Weeks_____

**Patient Signature: _____ Date: _____**

## PAST MEDICAL HISTORY:

Have you ever been treated for any of the following:

| | | | |
|---|---|---|---|
| Anemia | YES - NO | Bleeding Disorders | YES - NO |
| High Blood Pressure | YES - NO | Heart Attack or MI | YES - NO |
| Claustrophobia | YES - NO | Anxiety or Panic Disorder | YES - NO |
| Thyroid Disease | YES - NO | Osteoporosis | YES - NO |
| Ulcer | YES - NO | HIV or AIDS | YES - NO |
| Cancer | YES - NO | Hepatitis | YES - NO |
| Asthma | YES - NO | Liver Disease | YES - NO |
| Epilepsy or Seizures | YES - NO | Kidney Disease | YES - NO |
| Stroke or CVA or TIA | YES - NO | Emphysema or COPD | YES - NO |
| Diabetes | YES - NO | Alcohol or Drug Abuse | YES - NO |

If YES, Explain details or list any other serious medical conditions not listed above

_____

Any drug allergies: _____

Do you have any health problems or disorders that the doctor should know about? [] Yes [] No

If yes, explain _____

**CURRENT MEDICATIONS:** Please list ALL medications you currently take to include vitamins, herbal supplements, Over-the-counter medications as well as pain medications, muscle relaxers or anti-inflammatory:

| Medication | Dosage | Frequency | Reason | Taking |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**SURGICAL HISTORY:**

| Type of Surgery | Date | Surgeon | City |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Patient Signature: _____ Date: _____**

# REVIEW OF SYSTEMS:

Do you currently have or have had any problems with:

| **Constitutional** | | *Circle One* | Details |
|---|---|---|---|
| Fever or Chills | _____ | YES - NO | _____ |
| Weight Loss or Gain | _____ | YES - NO | _____ |
| Chronic Fatigue | _____ | YES - NO | _____ |
| Night Sweats | _____ | YES - NO | _____ |
| **Eyes** | | | |
| Wear Glasses or Contacts | _____ | YES - NO | _____ |
| Dry Eyes | _____ | YES - NO | _____ |
| Double Vision | _____ | YES - NO | _____ |
| Blurred Vision | _____ | YES - NO | _____ |
| Vision Loss | _____ | YES - NO | _____ |
| Glaucoma | _____ | YES - NO | _____ |
| Cataracts | _____ | YES - NO | _____ |
| Previous Injuries | _____ | YES - NO | _____ |
| **Ear, Nose, Throat and Mouth** | | | |
| Wearing Hearing Aids | _____ | YES - NO | _____ |
| Hearing loss | _____ | YES - NO | _____ |
| Balance Disturbance | _____ | YES - NO | _____ |
| Speech Difficulties | _____ | YES - NO | _____ |
| Post Nasal Drip | _____ | YES - NO | _____ |
| Sinus Headaches | _____ | YES - NO | _____ |
| Sore Throats | _____ | YES - NO | _____ |
| Swallowing Problems | _____ | YES - NO | _____ |
| **Cardiovascular** | | | |
| Chest Pain or Angina | _____ | YES - NO | _____ |
| High Blood Pressure | _____ | YES - NO | _____ |
| Irregular Heart Rate | _____ | YES - NO | _____ |
| History of Heart Murmur | _____ | YES - NO | _____ |
| High Cholesterol | _____ | YES - NO | _____ |
| Swelling in Ankles/Feet | _____ | YES - NO | _____ |
| History of DVT | _____ | YES - NO | _____ |
| Cardiac Stents | _____ | YES - NO | _____ |
| Cardiac Catheterization | _____ | YES - NO | _____ |
| Pacemaker | _____ | YES - NO | Date of last EKG:_____ Stress Test:_____ |

**Patient Signature: _____ Date: _____**

**REVIEW OF SYSTEMS CONTINUED:**

| **Respiratory** | | *Circle One* | Details |
|---|---|---|---|
| Shortness of Breath | _____ | YES - NO | _____ |
| Chronic Cough | _____ | YES - NO | _____ |
| Bloody Sputum | _____ | YES - NO | _____ |
| History of Pneumonia | _____ | YES - NO | _____ |
| History of PE (pulmonary embolism) | _____ | YES - NO | _____ |
| **Gastrointestinal** | | | |
| Indigestion or Heartburn | _____ | YES - NO | _____ |
| Nausea | _____ | YES - NO | _____ |
| Vomiting | _____ | YES - NO | _____ |
| Abdominal Pain | _____ | YES - NO | _____ |
| Diarrhea | _____ | YES - NO | _____ |
| Constipation | _____ | YES - NO | _____ |
| Blood in Stool | _____ | YES - NO | _____ |
| **Genitourinary Frequent Urinary Tract** | | | |
| Infections | _____ | YES - NO | _____ |
| Blood in Urine | _____ | YES - NO | _____ |
| Difficulty Starting or Stopping Stream | _____ | YES - NO | _____ |
| Loss of Urine | _____ | YES - NO | _____ |
| Loss of Urine with Cough or Sneeze Only | _____ | YES - NO | _____ |
| Kidney Stone | _____ | YES - NO | _____ |
| **Musculoskeletal** | | | |
| Neck Pain | _____ | YES - NO | _____ |
| Does Neck Pain Radiate Into the Arm | _____ | YES - NO | _____ |
| Back Pain | _____ | YES - NO | _____ |
| Does Back Pain Radiate Into the Leg | _____ | YES - NO | _____ |
| Shoulder Pain | _____ | YES - NO | _____ |
| Knee Wrist Ankle Jaw Pain | _____ | YES - NO | _____ |
| Joint Pain or Swelling | _____ | YES - NO | _____ |
| Osteoporosis | _____ | YES - NO | _____ |
| **Skin ( Integumentary)** | | | |
| Skin Disease | _____ | YES - NO | _____ |
| Rashes | _____ | YES - NO | _____ |

**Patient Signature: _____ Date: _____**

| **Neurological** | *Circle One* | Details |
|---|---|---|
| Headaches | YES - NO | |
| Disorientation | YES - NO | |
| Difficulty with Speech | YES - NO | |
| Fainting Spells or “Blacking Out” | YES - NO | |
| Problems with Memory | YES - NO | |
| **Psychiatric** | | |
| Anxiety | YES - NO | |
| Depression | YES - NO | |
| Suicidal Thoughts | YES - NO | |
| Hallucinations | YES - NO | |
| History of Dementia | YES - NO | |
| Other Psychiatric Disorders: | | |
| **Endocrine** | | |
| Excessive Thirst or Urination | YES - NO | |
| Hormone Problems | YES - NO | |
| **Hematologic / Lymphatic** | | |
| Persistent Swollen Glands or Lymph Nodes | YES - NO | |
| Blood Transfusion | YES - NO | |
| If Yes, When? | | |
| **Allergic/ Immunologic** | | |
| Food Allergies | YES - NO | |
| Immunologic Disorders | YES - NO | |
| **Male Reproduction** | | |
| Difficulty with Erection | YES - NO | |
| Diminished Sexual Drive | YES - NO | |
| Prostate Enlargement | YES - NO | |
| **Female Reproduction** | | |
| Pregnant | YES - NO | |
| Menopause | YES - NO | |
| Tubal Ligation or Hysterectomy | YES - NO | |

I have reviewed the above medical information:

| | | |
|---|---|---|
| **Provider Name** | **Provider Signature** | **Date** |

The Information I have provided is to the best of my knowledge:

**Patient Signature:** _____ **Date:** _____