

LAROCCA INJURY CENTERS

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Land o' Lakes, FL 34638
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Partner Office

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

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St. Petersburg, FL 33709
P: (727) 797-7090

3306 us 19 #B
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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

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Tampa, FL 33607
P: (813)898-8888

7425 N Tamiami Trail
Sarasota, FL 34243
P: (941) 500-1116

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

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St. Petersburg, FL 33712
P: (727) 328-0000
Partner Office

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

9384 N 56th St,
Temple Terrace,
FL 33617
P:(813) 988-8998

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	<u>Circle One</u>	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:** _____

NeurologicalCircle 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:** _____