CONFIDENTIAL PATIENT INFORMATION

Connecticut Orthopedic Rehabilitation Associates

Date: _____

Patient Name: _____ Date of Birth: _____ Gender: M F

Home Phone #: (___) _____ Mobile #: (___) _____ SS#: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Employer's Name: _____ Employer Phone: (___) _____

Emergency Contact: _____ Emergency Phone: (___) _____

Auto Insurance Company: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Adjuster: _____ Adjuster Phone : (___) _____ ext. _____

Claim Number: _____ Insured's Name: _____

Health Insurance Company: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Phone Number: (___) _____ Patient ID #: _____

Insured's Name: _____

Representing Attorney: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Phone Number: (___) _____ Fax #: _____

QUESTIONNAIRE (GENERAL INFOMRATION)

Patient Name: _____ **Date Injury Occurred:** _____

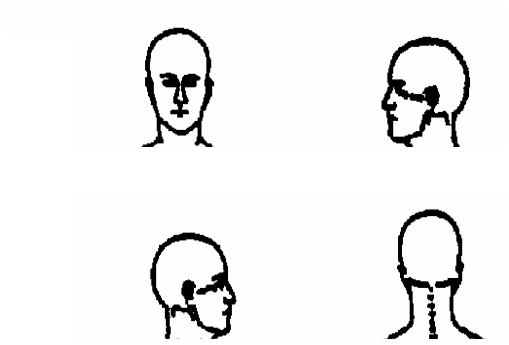
What medications are you currently taking at this time? _____

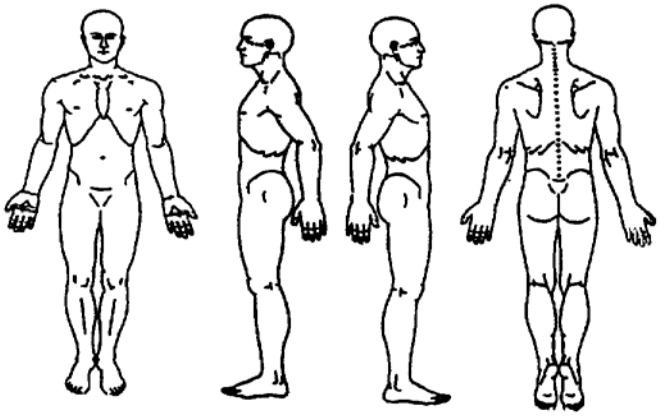
Do you or your family have any medical problems? _____
(Diabetes - High Blood Pressure - Cancer - Etc…)

Do you Smoke? Yes No How often? _____
(circle)

Do you Drink? Yes No How often? _____
(circle)

Please mark your areas of pain or discomfort on the figures below:





When your accident occurred, did you feel any tearing or ripping?	Yes	No
Are your symptoms affecting your work or daily activities?	Yes	No
What time of the day is the pain / discomfort the worse?	Morning	Afternoon Night
	(circle)	
Do you have difficulty sleeping?	Yes	No
What posture(s) aggravates the pain / discomfort?	_____	
What affects the pain / discomfort more?	Heat	Cold
Does the pain / discomfort wake you up at night?	Yes	No
Does the pain go up and down your spine?	Yes	No
Does aspirin relieve your pain?	Yes	No
Does coughing or sneezing increase you pain?	Yes	No

CORA
Connecticut Orthopedic Rehabilitation Associates

QUESTIONNAIRE (ACCIDENT)

Patient Name: _____ **Date Injury Occurred:** _____

1. Is your injury the result of an accident? Yes No
(circle)

2. Type of accident: Auto Worker's Comp Other
(circle)

3. How long have you been experiencing symptoms of your injury? _____

4. Are you symptoms getting worse? Yes No Constant Comes and Goes
(circle)

5. If your accident occurred at work, what happened? _____

_____

6. If you were in an auto accident, were you the: ___Driver ___Front Passenger ___Rear Passenger

7. Were you wearing a seatbelt? Yes No
(circle)

8. Did you lose consciousness in accident? Yes No How long? _____
(circle)

9. Was your vehicle stopped or moving at the time of the accident? _____

10. Were you looking (Forward, Down, Right or Left) at time of accident? _____

11. Did any part of your body hit inside the vehicle? _____

12. Did you have immediate pain after the accident occurred? _____

13. Did you go to the hospital? Yes No
(circle)

14. Name of the hospital? _____

15. What were your symptoms at that time? _____

16. Did you receive X-Rays? Yes No
(circle)

17. What part of the body? _____

18. What other tests were performed? _____

CORA
Connecticut Orthopedic Rehabilitation Associates

QUESTIONNAIRE (LOWER BACK / NECK / DISABILITY)

Patient Name: _____ **Date Injury Occurred:** _____

LOWER BACK SYMPTOMS

Are you experiencing lower back pain?	Yes	No
Do you have numbness or tingling in your feet?	Yes	No
Does the pain go down your legs?	Yes	No
Does the pain radiate into your stomach?	Yes	No
Is there impairment of bowel function?	Yes	No
Are you experiencing knee pain?	Yes	No
Are you experiencing ankle pain?	Yes	No

NECK SYMPTOMS

Are you experiencing neck pain?	Yes	No

What type of pain(s) are you experiencing? _____

(Exp: Stabbing, Throbbing, Sharp, Dull, Cramping, Grabbing)

Is there pain in your:	Left Arm	Left Shoulder
	Right Arm	Right Shoulder
Do you feel numbness in your arms?	Yes	No
Do you feel numbness in your hands?	Yes	No
Do you have difficulty swallowing?	Yes	No
Do you have chest pain?	Yes	No
Has your nervousness increased?	Yes	No
Does the neck pain affect your vision, hearing, or balance?	Yes	No

DISABILITY

How many day or weeks of work have you lost? _____

What physical restrictions do you have? _____

CORA
Connecticut Orthopedic Rehabilitation Associates