LOUISIANA
HEALTH & INJURY CENTERS

CONFIDENTIAL PATIENT INFORMATION

Date _____

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

CELL PHONE: _____ SEX: _____ MARITAL STATUS: _____ D.O.B.: _____ AGE: _____

S.S. #: _____ # OF CHILDREN: _____ D.L. #: _____

EMPLOYER: _____ OCCUPATION: _____

NAME OF SPOUSE: _____ CELL PHONE: _____

NAME OF NEAREST RELATIVE: _____ HOME PHONE: _____
(NOT LIVING WITH YOU)

TYPE OF ACCIDENT: ❑ NONE ❑ WORK RELATED ❑ AUTO ACCIDENT ❑ SLIP AND FALL ❑ OTHER

DATE OF ACCIDENT: _____

BRIEFLY DESCRIBE SYMPTOMS: _____

_____

LIST OTHER DOCTORS SEEN FOR THIS CONDITION: _____

MEDICAL HISTORY

❑ AIDS
❑ HIV
❑ ANEMIA
❑ ASTHMA
❑ CANCER
❑ CONVULSIONS
❑ DIABETES
❑ DIGESTIVE DISORDER
❑ EPILEPSY
❑ HEART TROUBLE
❑ REPRODUCTIVE DISORDERS
❑ HIGH BLOOD PRESSURE
❑ KIDNEY DISORDER
❑ MULTIPLE SCLEROSIS
❑ MUSCULAR DYSTROPHY
❑ POLIO
❑ HEPATITIS
❑ RHEUMATIC FEVER
❑ RHEUMATISM
❑ SCARLET FEVER
❑ TUBERCULOSIS
❑ VENEREAL DISEASE
❑ GERMAN MEASLES

ARE YOU PREGNANT? ❑ YES ❑ NO IF SO, WHAT IS YOUR DUE DATE? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑ YES ❑ NO IF SO, WHAT KINDS? _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE PAST YEAR? ❑ YES ❑ NO

DESCRIBE CONDITION: _____

DO YOU HAVE HEALTH INSURANCE? ❑ YES ❑ NO

NAME OF INS CO: _____ PHONE: _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER'S S.S. #: _____

MEMBER #: _____ GROUP #: _____

PATIENT SIGNATURE: _____ DATE: _____

LOUISIANA
HEALTH & INJURY CENTERS

ACCIDENT INFORMATION

DATE OF ACCIDENT: _____ TIME OF ACCIDENT: _____ ❑ AM ❑ PM

WORK RELATED ACCIDENT VICTIMS ONLY:

EMPLOYER: _____ TYPE OF BUSINESS: _____ PHONE: _____

HAS ACCIDENT BEEN REPORTED TO SUPERVISOR/EMPLOYER? ❑ YES ❑ NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? ❑ YES ❑ NO

TRAFFIC ACCIDENT VICTIMS ONLY:

WERE YOU THE: ❑ DRIVER ❑ PASSENGER ❑ PEDESTRIAN

IF PASSENGER, PLEASE INDICATE YOUR LOCATION IN THE VEHICLE: _____

YEAR/MAKE/MODEL OF VEHICLE YOU WERE IN:_____

YEAR/MAKE/MODEL OF OTHER VEHICLE INVOLVED IN THIS ACCIDENT: _____

WAS ACCIDENT REPORTED TO POLICE DEPARTMENT? ❑ YES ❑ NO

WERE ANY CITATIONS ISSUED? ❑ YES ❑ NO TO WHOM? _____

ACCIDENT DESCRIPTION:

EXPLAIN HOW THE ACCIDENT HAPPENED: _____

_____

DID YOU GO TO THE HOSPITAL OR ANOTHER DOCTOR AFTER THE ACCIDENT? ❑ YES ❑ NO
WHERE DID YOU GO? _____
WHEN DID YOU GO? _____
HOW DID YOU GET THERE? ❑ PRIVATE TRANSPORTATION ❑ AMBULANCE

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

❑ BENDING	❑ TURNING HEAD	❑ SNEEZING	❑ LIFTING
❑ STANDING	❑ REACHING	❑ SITTING	❑ WALKING
❑ STRAINING AT STOOL	❑ LYING DOWN	❑ COUGHING	

PLEASE CHECK THE FOLLOWING SYMPTOMS YOU MAY BE EXPERIENCING:

❑ BLURRED VISION	❑ FATIGUE	❑ SHORTNESS IN BREATH	❑ HEAD SEEMS TOO HEAVY
❑ BUZZING IN EARS	❑ DEPRESSION		
❑ MUSCLE JERKING	❑ INSOMNIA	❑ STIFF NECK	❑ CONSTIPATION
❑ FAINTING	❑ NUMBNESS IN FINGERS	❑ STOMACH UPSET	❑ LOSS OF BALANCE
❑ DIARRHEA		❑ NUMBNESS IN TOES	
❑ DIZZINESS	❑ PINS AND NEEDLES IN ARMS	❑ PINS AND NEEDLES IN LEGS	
❑ HEADACHES			

SYMPTOMS OTHER THAN ABOVE:_____

PATIENT SIGNATURE: _____ DATE: _____

LOUISIANA
HEALTH & INJURY CENTERS

AUTOMOBILE ACCIDENT QUESTIONNAIRE

DATE _____

PATIENT'S NAME _____

DATE OF ACCIDENT _____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

VEHICLE TYPE:
❑ CAR ❑ PICKUP
❑ VAN ❑ TRUCK
❑ STATION WAGON ❑ BUS
❑ OTHER_____

VEHICLE SIZE:
❑ SUBCOMPACT ❑ FULL-SIZE
❑ COMPACT ❑ MINI
❑ MID-SIZE ❑ LIGHT
❑ HEAVY ❑ OTHER_____

YOUR POSITION IN THE VEHICLE:
❑ DRIVER
❑ PASSENGER ---------- LOCATION: ❑ LEFT ❑ MIDDLE ❑ RIGHT
❑ OTHER_____ ❑ FRONT PASSENGER ❑ REAR PASSENGER ❑ THIRD SEAT (REAR)

SPEED OF YOUR VEHICLE:
❑ STOPPED ❑ MOVING MODERATELY
❑ PARKED ❑ MOVING FAST
❑ SLOWING ❑ MOVING AT APPROX. _____MPH
❑ MOVING SLOWLY

WHY VEHICLE WAS SLOWED OR STOPPED:
❑ TRAFFIC SIGNAL ❑ PARKING
❑ PEDESTRIAN ❑ TRAFFIC
❑ STOP SIGN ❑ BUSY INTERSECTION

COLLISION TYPE:
❑ DRIVER SIDE IMPACT ❑ HEAD ON COLLISION
❑ PASSENGER SIDE IMPACT ❑ REAR IMPACT
❑ FRONT IMPACT ❑ PEDESTRIAN INCIDENT

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

VEHICLE TYPE:
❑ CAR ❑ PICKUP
❑ VAN ❑ TRUCK
❑ STATION WAGON ❑ BUS
❑ OTHER_____

VEHICLE SIZE:
❑ SUBCOMPACT ❑ FULL-SIZE
❑ COMPACT ❑ MINI
❑ MID-SIZE ❑ LIGHT
❑ HEAVY ❑ OTHER_____

CONDITIONS AT THE TIME OF ACCIDENT:

TIME OF DAY:
❑ FULL DAYLIGHT
❑ DAWN
❑ DUSK
❑ NIGHT

ROAD CONDITIONS:
❑ DRY
❑ DAMP
❑ WET
❑ SNOW COVERED
❑ ICE COVERED
❑ PATCHY ICE/SNOW

VISIBILITY:
❑ EXCELLENT
❑ GOOD
❑ FAIR
❑ POOR

VISIBILITY COMPROMISED BY:
❑ BRIGHTNESS
❑ DARKNESS
❑ RAIN
❑ SNOW
❑ FOG
❑ TRAFFIC

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

WERE YOU...
❑ TOTALLY UNAWARE THAT THE ACCIDENT WAS IMPENDING
❑ AWARE THAT THE ACCIDENT WAS IMPENDING
❑ AWARE THAT THE ACCIDENT WAS IMPENDING AND BRACED FOR IT

RESTRAINTS: (CHECK ALL THAT APPLY)
❑ SEAT BELT
❑ SHOULDER HARNESS
❑ NO RESTRAINTS

IF YOU WERE THE DRIVER OF THE VEHICLE, WAS YOUR FOOT ON THE BRAKE PEDAL? ❑ YES ❑ NO ❑ KNOCKED OFF BY IMPACT

WAS THE AIR BAG DEPLOYED?
❑ CAR NOT EQUIPPED WITH AIR BAG
❑ AIR BAG DEPLOYED
❑ AIR BAG NOT DEPLOYED

WHAT POSITION WAS YOUR HEADREST IN?
❑ HIGH POSITION
❑ MIDDLE POSITION
❑ LOW POSITION

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POSITION OF YOUR HEAD AT TIME OF IMPACT:
- ❑ FACING STRAIGHT AHEAD
- ❑ TILTED FORWARD
- ❑ ROTATED TO THE LEFT
- ❑ ROTATED TO THE RIGHT

WAS YOUR HEAD THROWN...?
- ❑ BACKWARD AND THEN FORWARD
- ❑ FORWARD AND THEN BACKWARD
- ❑ TO THE LEFT
- ❑ TO THE LEFT THEN THE RIGHT
- ❑ TO THE RIGHT
- ❑ TO THE RIGHT THEN THE LEFT

POSITION OF YOUR BODY AT TIME OF IMPACT:
- ❑ STRAIGHT
- ❑ TILTED FORWARD
- ❑ ROTATED TO THE LEFT
- ❑ ROTATED TO THE RIGHT

WAS YOUR BODY THROWN...?
- ❑ BACKWARD AND THEN FORWARD
- ❑ FORWARD AND THEN BACKWARD
- ❑ TO THE LEFT
- ❑ TO THE LEFT THEN THE RIGHT
- ❑ TO THE RIGHT
- ❑ TO THE RIGHT THEN THE LEFT
- ❑ ACROSS THE VEHICLE
- ❑ OUTSIDE THE VEHICLE
- ❑ UNDER THE VEHICLE

DAMAGE TO THE VEHICLE YOU WERE IN:
- ❑ INCURRED MINIMAL DAMAGE
- ❑ INCURRED MODERATE DAMAGE
- ❑ INCURRED SEVERE DAMAGE
- ❑ WAS TOTALLED
- ❑ NOT KNOWN

CITATIONS:
- ❑ NONE ISSUED
- ❑ YOURSELF
- ❑ DRIVER OF VEHICLE PATIENT WAS A PASSENGER OF
- ❑ DRIVER OF OTHER VEHICLE
- ❑ NOT SURE

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

HEAD:
- ❑ STEERING WHEEL
- ❑ DASHBOARD
- ❑ WINDSHIELD
- ❑ ARMREST
- ❑ HEADREST
- ❑ REAR VIEW MIRROR
- ❑ LEFT DOOR
- ❑ RIGHT DOOR
- ❑ LEFT WINDOW
- ❑ RIGHT WINDOW
- ❑ CONSOLE
- ❑ GEAR SHIFT
- ❑ FRONT SEAT
- ❑ BACK SEAT

TORSO:
- ❑ STEERING WHEEL
- ❑ DASHBOARD
- ❑ WINDSHIELD
- ❑ ARMREST
- ❑ HEADREST
- ❑ REAR VIEW MIRROR
- ❑ LEFT DOOR
- ❑ RIGHT DOOR
- ❑ LEFT WINDOW
- ❑ RIGHT WINDOW
- ❑ CONSOLE
- ❑ GEAR SHIFT
- ❑ FRONT SEAT
- ❑ BACK SEAT

LEFT ARM:
- ❑ STEERING WHEEL
- ❑ DASHBOARD
- ❑ WINDSHIELD
- ❑ ARMREST
- ❑ HEADREST
- ❑ REAR VIEW MIRROR
- ❑ LEFT DOOR
- ❑ RIGHT DOOR
- ❑ LEFT WINDOW
- ❑ RIGHT WINDOW
- ❑ CONSOLE
- ❑ GEAR SHIFT
- ❑ FRONT SEAT
- ❑ BACK SEAT

RIGHT ARM:
- ❑ STEERING WHEEL
- ❑ DASHBOARD
- ❑ WINDSHIELD
- ❑ ARMREST
- ❑ HEADREST
- ❑ REAR VIEW MIRROR
- ❑ LEFT DOOR
- ❑ RIGHT DOOR
- ❑ LEFT WINDOW
- ❑ RIGHT WINDOW
- ❑ CONSOLE
- ❑ GEAR SHIFT
- ❑ FRONT SEAT
- ❑ BACK SEAT

LEFT LEG:
- ❑ STEERING WHEEL
- ❑ DASHBOARD
- ❑ WINDSHIELD
- ❑ ARMREST
- ❑ HEADREST
- ❑ REAR VIEW MIRROR
- ❑ LEFT DOOR
- ❑ RIGHT DOOR
- ❑ LEFT WINDOW
- ❑ RIGHT WINDOW
- ❑ CONSOLE
- ❑ GEAR SHIFT
- ❑ FRONT SEAT
- ❑ BACK SEAT

RIGHT LEG:
- ❑ STEERING WHEEL
- ❑ DASHBOARD
- ❑ WINDSHIELD
- ❑ ARMREST
- ❑ HEADREST
- ❑ REAR VIEW MIRROR
- ❑ LEFT DOOR
- ❑ RIGHT DOOR
- ❑ LEFT WINDOW
- ❑ RIGHT WINDOW
- ❑ CONSOLE
- ❑ GEAR SHIFT
- ❑ FRONT SEAT
- ❑ BACK SEAT

LOUISIANA
HEALTH & INJURY CENTERS

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

DID YOU LOSE CONSCIOUSNESS?
❑ YES
❑ NO

IMMEDIATELY FOLLOWING THE ACCIDENT, DID YOU FEEL...?
❑ DIZZY ❑ WEAK
❑ DAZED ❑ NERVOUS
❑ DISORIENTED ❑ NAUSEATED

WERE YOU ABLE TO WALK UNAIDED?
❑ YES
❑ NO

WHERE DID YOU GO?
❑ DROVE HOME ❑ DROVE TO WORK
❑ WAS DRIVEN HOME ❑ WAS DRIVEN TO WORK
❑ DROVE TO HOSPITAL ❑ DROVE TO SCHOOL
❑ WAS DRIVEN TO HOSPITAL ❑ WAS DRIVEN TO SCHOOL
❑ TAKEN TO HOSPITAL VIA AMBULANCE

NEXT DAY DISCOMFORT...?
❑ INCREASED ❑ DECREASED ❑ SAME

IN WHAT AREAS DID YOU IMMEDIATELY FEEL PAIN?

❑ HEAD	SHOULDER -	❑ LEFT	❑ RIGHT	HIP -	❑ LEFT	❑ RIGHT
❑ NECK	ARM -	❑ LEFT	❑ RIGHT	THIGH -	❑ LEFT	❑ RIGHT
❑ UPPER BACK	ELBOW -	❑ LEFT	❑ RIGHT	KNEE -	❑ LEFT	❑ RIGHT
❑ MID BACK	WRIST -	❑ LEFT	❑ RIGHT	CALF -	❑ LEFT	❑ RIGHT
❑ RIBS	HAND -	❑ LEFT	❑ RIGHT	ANKLE -	❑ LEFT	❑ RIGHT
❑ CHEST	FINGERS -	❑ LEFT	❑ RIGHT	FOOT -	❑ LEFT	❑ RIGHT
❑ ABDOMEN	BUTTOCK -	❑ LEFT	❑ RIGHT	TOES -	❑ LEFT	❑ RIGHT
❑ LOW BACK	❑ PELVIS					

IN WHAT AREAS DID YOU EXPERIENCE LACERATIONS (CUTS)?

❑ HEAD	SHOULDER -	❑ LEFT	❑ RIGHT	HIP -	❑ LEFT	❑ RIGHT
❑ NECK	ARM -	❑ LEFT	❑ RIGHT	THIGH -	❑ LEFT	❑ RIGHT
❑ UPPER BACK	ELBOW -	❑ LEFT	❑ RIGHT	KNEE -	❑ LEFT	❑ RIGHT
❑ MID BACK	WRIST -	❑ LEFT	❑ RIGHT	CALF -	❑ LEFT	❑ RIGHT
❑ RIBS	HAND -	❑ LEFT	❑ RIGHT	ANKLE -	❑ LEFT	❑ RIGHT
❑ CHEST	FINGERS -	❑ LEFT	❑ RIGHT	FOOT -	❑ LEFT	❑ RIGHT
❑ ABDOMEN	BUTTOCK -	❑ LEFT	❑ RIGHT	TOES -	❑ LEFT	❑ RIGHT
❑ LOW BACK	❑ PELVIS					

AT THE HOSPITAL, WHAT AREAS WERE X-RAYED?

❑ HEAD	SHOULDER -	❑ LEFT	❑ RIGHT	HIP -	❑ LEFT	❑ RIGHT
❑ NECK	ARM -	❑ LEFT	❑ RIGHT	THIGH -	❑ LEFT	❑ RIGHT
❑ UPPER BACK	ELBOW -	❑ LEFT	❑ RIGHT	KNEE -	❑ LEFT	❑ RIGHT
❑ MID BACK	WRIST -	❑ LEFT	❑ RIGHT	CALF -	❑ LEFT	❑ RIGHT
❑ RIBS	HAND -	❑ LEFT	❑ RIGHT	ANKLE -	❑ LEFT	❑ RIGHT
❑ CHEST	FINGERS -	❑ LEFT	❑ RIGHT	FOOT -	❑ LEFT	❑ RIGHT
❑ ABDOMEN	BUTTOCK -	❑ LEFT	❑ RIGHT	TOES -	❑ LEFT	❑ RIGHT
❑ LOW BACK	❑ PELVIS					

WHERE DID YOU EXPERIENCE PAIN ON THE DAY FOLLOWING THE ACCIDENT?

❑ HEAD	SHOULDER -	❑ LEFT	❑ RIGHT	HIP -	❑ LEFT	❑ RIGHT
❑ NECK	ARM -	❑ LEFT	❑ RIGHT	THIGH -	❑ LEFT	❑ RIGHT
❑ UPPER BACK	ELBOW -	❑ LEFT	❑ RIGHT	KNEE -	❑ LEFT	❑ RIGHT
❑ MID BACK	WRIST -	❑ LEFT	❑ RIGHT	CALF -	❑ LEFT	❑ RIGHT
❑ RIBS	HAND -	❑ LEFT	❑ RIGHT	ANKLE -	❑ LEFT	❑ RIGHT
❑ CHEST	FINGERS -	❑ LEFT	❑ RIGHT	FOOT -	❑ LEFT	❑ RIGHT
❑ ABDOMEN	BUTTOCK -	❑ LEFT	❑ RIGHT	TOES -	❑ LEFT	❑ RIGHT
❑ LOW BACK	❑ PELVIS					

PATIENT'S SIGNATURE:_____

LOUISIANA
HEALTH & INJURY CENTERS

PATIENT: _____

ADDRESS: _____

_____

ATTORNEY: _____

INSURANCE CARRIER: _____

ASSIGNMENT OF PAYMENT

My attorney and/or insurance carrier are hereby authorized and requested to pay directly to **LOUISIANA HEALTH & INJURY CENTERS** any monies due on my account, the same to be deducted from settlement made on my behalf.

Dated at _____ am/pm this _____ day of _____, 20_____.
TIME DATE MONTH

_____ _____
Witness **Patient Signature**

AUTHORIZATION OF RELEASE OF CASE RECORDS

I hereby authorize **LOUISIANA HEALTH & INJURY CENTERS** to disclose my medical records or any information, which he may have acquired by examination or other means of my physical or mental condition; and I hereby release them of any consequences thereof.

Dated at _____ am/pm this _____ day of _____, 20_____.
TIME DATE MONTH

_____ _____
Witness **Patient Signature**

8312 Jefferson Highway
Baton Rouge, LA 70809

Tel: 225.752.2760
Fax: 225.751.6908

LOUISIANA
HEALTH & INJURY CENTERS

PATIENT NAME: _____

ADDRESS: _____

_____

DATE OF ACCIDENT: _____

TIME OF ACCIDENT: _____

Were you the: DRIVER PASSENGER PEDESTRIAN

If you were NOT the driver, who was? _____

Location of accident:_____

_____

Was any information exchanged? Any information that you have will be helpful.

Insured: _____
NAME OF OTHER DRIVER

Insurance Company: _____
OTHER VEHICLE

Phone Number: _____

Adjuster: _____

Claim Number: _____

8312 Jefferson Highway
Baton Rouge, LA 70809

Tel: 225.752.2760
Fax: 225.751.6908

LOUISIANA
HEALTH & INJURY CENTERS

CONSENT TO TREATMENT OF A MINOR CHILD

I, _____ hereby consent to **Dr. Michael Goff**
(PRINT NAME OF PARENT/LEGAL GUARDIAN)

and his staff to treat _____ as he sees fit.
(PRINT NAME OF MINOR CHILD)

_____
Signature of Parent/Legal Guardian

8312 Jefferson Highway
Baton Rouge, LA 70809

Tel: 225.752.2760
Fax: 225.751.6908

LOUISIANA
HEALTH & INJURY CENTERS

AUTHORIZATION FOR RELEASE OF RECORDS

PATIENT: _____

ADDRESS: _____

_____

I hereby authorize _____ to disclose to **LOUISIANA HEALTH & INJURY CENTERS** or their agents any information, which he may have acquired by examination or other means of my physical or mental condition; and I hereby, release him of any consequences thereof.

Dated at _____ this _____ day of _____, 20_____.
TIME DATE MONTH

_____ _____
Patient Signature **Witness**

_____ _____
Date of Birth **Date of Accident**

_____ _____
Patient Social Security Number **Fax#**

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