

**Private Insurance**

**DATE:** \_\_\_\_\_

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A Professional Corporation  
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**PATIENT INJURY HISTORY**

**Patient Name:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Right Handed or Left Handed**

**Body Part Injured (please indicate right or left):** \_\_\_\_\_

**Did you have a specific injury? Yes No (IF NO INJURY SKIP TO DESCRIBE SYMPTOMS)**

**Date of Injury:** \_\_\_\_\_

**How were you injured?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Place of injury:** \_\_\_\_\_

**Describe symptoms:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**When did they begin?** \_\_\_\_\_

**PLEASE LIST TYPE OF TREATMENT RECEIVED FROM FIRST TO LAST**

**Doctor's Name:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**Hospital/Clinic:** \_\_\_\_\_

**Date of initial visit** \_\_\_\_\_ **Date of last visit:** \_\_\_\_\_

**Treatment Received (include any testing, medicine, surgeries, etc.):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**IF HAD MORE THAN ONE TREATMENT PLEASE ASK RECEPTIONIST FOR AN ADDITIONAL SHEET OF PAPER TO FILL. THANK YOU.**

**LIST ANY MAJOR MEDICAL ILLNESSES AND MEDICATION(S) TAKING**

<b>ILLNESS</b>	<b>MEDICINE (include dosage)</b>
1.	
2.	
3.	

**LIST ANY MEDICINE ALLERGIC TO AND SPECIFIC REACTIONS**

<b>MEDICATION</b>	<b>REACTIONS</b>
1.	
2.	
3.	

**LIST ANY SURGERIES YOU'VE HAD , DATE AND HOSPITAL/SURGEON**

<b>SURGERY</b>	<b>DATE</b>	<b>HOSPITAL/DOCTOR</b>
1.		
2.		
3.		

**LIST ANY INJURIES IN THE PAST THAT WERE NOT SURGICAL**

<b>BODY PART</b>	<b>DATE OF INJURY</b>
1.	
2.	
3.	