PATIENT INTAKE FORM -- Personal Injury

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We are happy to help.

CONFIDENTIAL PATIENT INFOR	MATION					
Name			Date /	/ S	/S -	
First	MI	Last				
Address			City		_ State	Zip
Home Phone	······	Work Phone		Cell Ph	one	
Birth Date///	Height	Weight	e-mail addi	ress:		
Sex: Female Male	Status: 1	Minor Married	Single Other			
Your Employer			Occupation			
Business Address						
Spouse/ Parent's Name						I
Who may we thank for referring						
Person to contact in case of an e						
INSURANCE CO.						
Name on Policy (if not self)						
Responsible Party's Name						
Address						
ATTORNEY						
Address						
HEALTH HISTORY						
Please check the following symp	ptoms you ha	ve noticed SINCE	THE ACCIDENT (A	Δ) or <u>BEFO</u>	RE THE A	CCIDENT (□):
Δ \Box Headaches		$\Delta \square$ Irritability			Loss of Sr	
$\Delta \square$ Neck Pain		$\Delta \square$ Mood Swir	ngs	Δ \Box	Loss of Ta	iste
$\Delta \square$ Neck Stiffness		$\Delta \square$ Sleeping Pi	g Problems Δ		Upset Stomach	
$\Delta \ \Box$ Mid Back Pain		$\Delta \ \square$ Fatigue		Δ \Box	Constipatio	on
$\Delta \square$ Low Back Pain		$\Delta \square$ Depression		Δ \Box	Diarrhea	
Δ 🗆 Arm Pain		$\Delta \square$ Chest Pain		Δ \Box	Urinary Pr	oblems
$\Delta \square$ Leg Pain		$\Delta \square$ Shortness of	of Breath	Δ \Box	Heartburn	
Δ \Box Pins and Needles in Arm	8	$\Delta \square$ Cold Sweat	ts	Δ \Box	Ulcers	
Δ \Box Pins and Needles in Legs		$\Delta \square$ Fever		Δ \Box	Allergies	
$\Delta \square$ Numbness in Fingers		$\Delta \square$ Fainting		Δ \Box	Menstrual	Pain
$\Delta \square$ Numbness in Toes		$\Delta \square$ Dizziness				Irregularity
$\Delta \square$ Cold Hands		$\Delta \square$ Loss of Bal	lance		Hot flashe	• •
$\Delta \square$ Cold Feet		Δ 🗆 Light Sensi				
Δ \Box Nervousness		$\Delta \square$ Ringing/B				
Δ \Box Tension		$\Delta \square$ Loss of Me				
Have <u>YOU</u> (Δ) or <u>A FAMILY</u>	MEMREP	(□) ever been die	gnosed with any of th	e following	conditions	
$\Delta \square \text{ AIDS/HIV}$		$\Delta \square$ Heart Disea		$\Delta \square$		
$\Delta \square$ AIDS/HIV $\Delta \square$ Cancer		$\Delta \square$ Heart Disea $\Delta \square$ Diabetes	50		Unknown	
				Δ \Box	UIIKIIUWII	

- $\Delta \square$ High Blood Pressure
- $\Delta \square$ Stroke

 Δ \Box Other_____

NATURE OF ACCIDENT Date of accident/ Time of Day	Location of accident					
Relative speed of you car (mph) What was the site of impact on your car? Behind Front Driver's Side Passenger's Side Were you wearing your seat belt? No Yes Were your brakes applied? No Yes PLEASE DESCRIBE THE ACCIDENT in your own wo	Relative speed of the other car(mph) Where were you sitting at the time of impact? Driver Passenger Front Back Did your airbags deploy? No Yes Did your seat back break? No Yes rds:					
List any parts of your body that struck the following vehicle	e parts during the accident:					
Dashboard:	Door:					
Windshield:	Door Window:					
Steering Wheel:	Other:					
Your Vehicle Type	Other Vehicle Type					
Did you lose consciousness? No Yes, if yes for how long	?					
ADDITIONAL INFORMATION:						
What was your mental and emotional state immediately following	lowing the accident?					
Were the police notified? No Yes Did you receiv	re medical attention at the scene of the accident? No Yes					
Where did you go immediately following the accident?						
Have you been treated by another doctor since the accident	? No Yes, If yes					
Please list the name of the doctor and address:						
Please explain what type of treatment you received	1:					
What type of X-rays were taken if any?						
Do you have any congenital (from birth) factors that may re	elate to this problem? No Yes,					
Do you have any previous illnesses which relate to this case	e No Yes,					
Have you ever been involved in an accident before? No	Yes,					
Have you lost time from work as a result of this accident?	No Yes, If yes					
Last day worked: // Type of employment:						
PLEASE DESCRIBE HOW YOU FELT:						
DURING the accident:						
IMMEDIATELY AFTER the accident:						
LATER THAT DAY:						
THE NEXT DAY:						
Please add any other information that you feel is pertinent:						

PLEASE LIST YOUR CURREN (chief complaint)	T AREAS OF COM	IPLAINT:		
1)	2)	3)	4)	
0 1 2 3 4 5 6 7 8 9 10				
CIRCLE THE NUMBER TH	AT BEST DESCR	RIBES THE INTENSITY	OF YOUR PAIN: $1 = M$	ild, 10 = Severe
PLEASE MARK YOUR ARE BODY DIAGRAM USING TI Dull Aching Stiffness Burning Tingling Numbness Sharp Shooting Other	HE FOLLOWING = D = A = S = B = T = N = !!! = XXX	1		
How often do you notice your s Does anything relieve your pain What activities are difficult to p Please describe any other activit	? erform? Sitting	Standing Walking	Bending Lying Down	
Is the condition getting worse?	No Yes			
Have you had this problem befo				
When?				
Have you had x-rays before? N			nat areas?	
I am currently taking the follow	ing medications fo	r the following reasons: N	one	
Surgical History: None				
For Women Only: Is there a pos				
Which best describes your healt	h goals: pain relie	only correct entire prob	olem wellness/ preventa	tive care
DATE://	SIGN	ATURE:		
	PAR	ENT/GUARDIAN:		