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 INFORMATION

Name_____ Date_____/_____/_____
First MI Last

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Birth Date_____/_____/_____ Height_____ Weight_____ e-mail address:_____

Sex: Female Male **Status:** Minor Married Single Other

Your Employer_____ Occupation_____

Business Address_____ City_____ State_____ Zip_____

Spouse/ Parent's Name_____ Phone_____

Who may we thank for referring you to us?_____

Person to contact in case of an emergency_____ Phone_____

INSURANCE CO. _____ Policy # _____

Name on Policy (if not self) _____

Responsible Party's Name _____ Agent's name _____

Address _____

ATTORNEY _____ Phone _____

Address _____

HEALTH HISTORY

Please check the following symptoms you have noticed **SINCE THE ACCIDENT** (Δ) or **BEFORE THE ACCIDENT** (□):

Δ □ Headaches	Δ □ Irritability	Δ □ Loss of Smell
Δ □ Neck Pain	Δ □ Mood Swings	Δ □ Loss of Taste
Δ □ Neck Stiffness	Δ □ Sleeping Problems	Δ □ Upset Stomach
Δ □ Mid Back Pain	Δ □ Fatigue	Δ □ Constipation
Δ □ Low Back Pain	Δ □ Depression	Δ □ Diarrhea
Δ □ Arm Pain	Δ □ Chest Pain	Δ □ Urinary Problems
Δ □ Leg Pain	Δ □ Shortness of Breath	Δ □ Heartburn
Δ □ Pins and Needles in Arms	Δ □ Cold Sweats	Δ □ Ulcers
Δ □ Pins and Needles in Legs	Δ □ Fever	Δ □ Allergies
Δ □ Numbness in Fingers	Δ □ Fainting	Δ □ Menstrual Pain
Δ □ Numbness in Toes	Δ □ Dizziness	Δ □ Menstrual Irregularity
Δ □ Cold Hands	Δ □ Loss of Balance	Δ □ Hot flashes
Δ □ Cold Feet	Δ □ Light Sensitivity with Eyes	Δ □ Other _____
Δ □ Nervousness	Δ □ Ringing/ Buzzing in Ears	Δ □ Other _____
Δ □ Tension	Δ □ Loss of Memory	

Have **YOU** (Δ) or **A FAMILY MEMBER** (□) ever been diagnosed with any of the following conditions**:**

Δ □ AIDS/HIV	Δ □ Heart Disease	Δ □ None
Δ □ Cancer	Δ □ Diabetes	Δ □ Unknown
Δ □ High Blood Pressure	Δ □ Stroke	Δ □ 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

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

PLEASE DESCRIBE THE ACCIDENT in your own words: _____

_____

_____

List any parts of your body that struck the following vehicle 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 the accident? _____

Were the police notified? No Yes Did you receive 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: _____

What type of X-rays were taken if any? _____

Do you have any congenital (from birth) factors that may relate to this problem? No Yes, _____

Do you have any previous illnesses which relate to this case 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 CURRENT AREAS OF COMPLAINT:
(chief complaint)

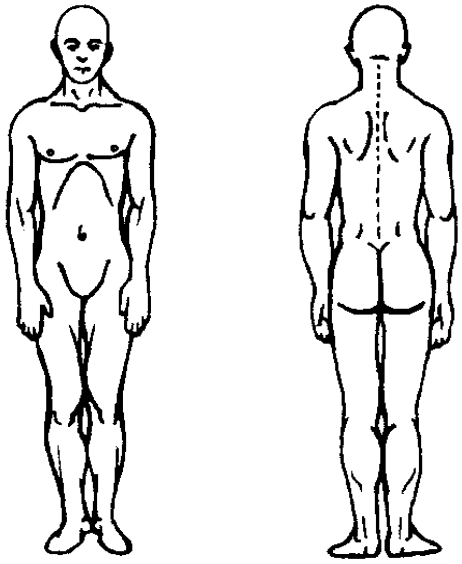
1) _____ 2) _____ 3) _____ 4) _____

0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10 0 1 2 3 4 5 6 7 8 9 10

CIRCLE THE NUMBER THAT BEST DESCRIBES THE INTENSITY OF YOUR PAIN: 1 = Mild, 10 = Severe

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

Dull	= D
Aching	= A
Stiffness	= S
Burning	= B
Tingling	= T
Numbness	= N
Sharp	= !!!
Shooting	= XXX
Other_____	= ***



How often do you notice your symptoms? Constantly Frequently Occasionally

Does anything relieve your pain?_____

What activities are difficult to perform? Sitting Standing Walking Bending Lying Down

Please describe any other activities that are restricted due to this injury?_____

_____

Is the condition getting worse? No Yes

Have you had this problem before? No Yes,

When?_____

Have you had x-rays before? No Yes, When? _____ What areas?

_____

I am currently taking the following medications for the following reasons: None

_____

_____

Surgical History: None _____

For Women Only: Is there a possibility that you may be pregnant? No Yes

Which best describes your health goals: pain relief only correct entire problem wellness/ preventative care

DATE: ___/___/___ **SIGNATURE:** _____

PARENT/GUARDIAN: _____