

## Personal Injury Intake Form

	File Number ( )
Patient Information:	
Today's Date	
NameI prefer to be called	Home Phone
I prefer to be called	Work Phone
Address	Email
	Social Security #
	Date of Birth
Sex	Date of Birth Beight lbs
Occupation	Marital Status
Employer	No of Children
Address	Condition (State Conditions and Cond
If minor, name of parent or guardian	
Who should we contact in case of an emergen	
Relation	Phone
Address	
Attorney	Phone
Primary Care Physician	Phone
How did you hear about our office?	
	☐ YES ☐ NO If so, whom?
Health Insurance Information: Insurance Company Policy Holder's Name Address	Policy number Social Security# Phone
Auto Insurance Information:	
Insurance Company	Policy number
Address	Phone
Adjustor Name	Claim #
Accident Information:	
	Was it reported to the police? ☐ YES ☐ NO
Was a traffic violation issued? ☐ YES ☐ NO	To whom?
Location of accident (Street, Town)	# of other passengers
Were there other witnesses? ☐ YES ☐ NO	
Please explain in detail how the accident occur	rred
Please list symptoms felt immediately after the	accident
In which direction were you headed?   □ N □	S □ E □ W Approx. speed of vehicleMPH
	ACC Form

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Were you		hicle come from the: <mark>□ FROI</mark> facing: <b>□ RIGHT □ LEFT</b> □		LEFT   OTHER
Were you we pour passed belt?   SHOULDER HARNESS   SHOP   SHOULDER HARNESS   SHOP   SHOULDER HARNESS   SHOP   SHOULDER HARNESS   SHOP				
Were you wearing a seat belt?   SHOULDER HARNESS   LAP HARNESS   Was the vehicle equipped with air bags?   YES   NO   Did they inflate?   YES   NO   Normal on wheel?   BOTH hands   ONE hand   What did your vehicle impact?   ANOTHER VEHICLE   OTHER   If another vehicle, what was the make/model?   Direction   Speed   MPH   Direction   Speed   MPH   Direction   Speed   MPH   Did your body strike anything in the vehicle?   YES   NO Describe   Did the accident render you unconscious?   YES   NO If yes, for how long?   Post-Injury Information:   Have you seen any other doctor(s) since the accident?   YES   NO Name   When did you go?   IMMEDIATELY   NEXT DAY   2 DAYS PLUS   NO Mame   When did you got there?   AMBULANCE   PRIVATE TRANSPORTATION   Name of hospital and/or attending doctor:   Was he/she a:   D.C.   M.D.   D.O.   D.D.S.   Please describe any treatment you received   Were X-Rays done?   YES   NO An MRI?   YES   NO CAT scan?   YES   NO Was medication prescribed?   YES   NO An MRI?   YES   NO Date(s)   Are your work activities restricted as a result of your injury?   YES   NO Indicate the symptoms that are a result of this accident:   DIZZINESS   DIFFICULTY SLEEPING   JAW PROBLEMS   NAUSEA   MEMORY LOSS   ARM/SHOULDER PAIN   IRRITABILITY   BACK PAIN   BACK STIFFNESS   DIFFICULTY SLEEPING   STOMACH UPSET   NUMB FEET/TOES   DIHER   DIA PRODUCTION   STAYED SAME since the accident?   Syour condition affecting your   WORK   SLEEP or   DAILY ROUTINE?Please explain   PILOROM   State   DAILY ROUTINE?Please explain   PILOROM   State   DAILY ROUTINE?Please explain   PILOROM   DAILY ROUTINE?Please explain   PILOROM   State   DAILY ROUTINE?Please explain   PILOROM   State   DAILY ROUTINE?Please explain   PILOROM   DAILY ROUTINE?Please explain   PILOROM   DAILY ROUTINE?Please explain   PILOROM   DAILY ROUTINE?Please explain   PILOROM				F PASSENGER?
Was the vehicle equipped with air bags?				
Were your brakes?   applied   partially applied   Hands on wheel?   BOTH hands   ONE hand What did your vehicle impact?   ANOTHER VEHICLE OTHER   Direction   Speed   MPH Did any part of your body strike anything in the vehicle?   YES   NO Describe   Did the accident render you unconscious?   YES   NO If yes, for how long?    Post-Injury Information:   Have you seen any other doctor(s) since the accident?   YES   NO Name   When did you go?   IMMEDIATELY   NEXT DAY   2 DAYS PLUS   How did you get there?   AMBULANCE   PRIVATE TRANSPORTATION   Name of hospital and/or attending doctor:   Was he/she a:   D.C.   M.D.   D.O.   D.D.S.   Please describe any treatment you received   Were X-Rays done?   YES   NO   An MRI?   YES   NO Date(s)   Are your work activities restricted as a result of your injury?   YES   NO Indicate the symptoms that are a result of this accident:   DIZZINESS   DIFFICULTY SLEEPING   JAW PROBLEMS   NAUSEA   MEMORY LOSS   ARM/SHOULDER PAIN   IRRITABILITY   BACK PAIN   BACK PA	- 불교교 사용 및 경기 시간 전쟁 전 프라이크 시간 기업			
What did your vehicle impact?				
Did any part of your body strike anything in the vehicle?   YES   NO Describe   Did the accident render you unconscious?   YES   NO If yes, for how long?	What did your vehicle imp	pact?   ANOTHER VEHICLE	F OTHER	Ti Hallao 🗆 OILE Halla
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Are your work activities restricted as a result of your injury?   YES   NO Indicate the symptoms that are a result of this accident:   DIZZINESS   DIFFICULTY SLEEPING   JAW PROBLEMS   NAUSEA   MEMORY LOSS   ARM/SHOULDER PAIN   IRRITABILITY   BACK PAIN   HEADACHE(S)   NUMB HANDS/FINGERS   FATIGUE   LOW BACK PAIN   BLURRED VISION   TENSION   CHEST PAIN   BACK STIFFNESS   BUZZING IN EAR   NECK PAIN   SHORT BREATH   LEG PAIN   LEG PAIN   DIANGEMENT   NUMB FEET/TOES   OTHER    Did you ever experience similar symptoms prior to the accident?   YES   NO   Has your condition   IMPROVED   WORSENED or   STAYED SAME since the accident?   Is your condition affecting your   WORK   SLEEP or   DAILY ROUTINE? Please explain    Please indicate your degree of difficulty (on a scale of 1-10, with 1 being comfortable, 5 being uncomfortable, and 10 being painful) in performing the following activities:   Lying on Back   Lying on Side   Lying on stomach   Sitting   Standing   Stretching   Lovemaking   Walking   Running   Sports   Working   Lifting   Reaching   How many hours are in your normal workday?	Have you missed any wor	rk since the accident?	S   NO Date(s)	
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MEMORY LOSS				□NAUSEA
HEADACHE(S)				
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□EARS RINGING □NECK STIFF □STOMACH UPSET □NUMB FEET/TOES □OTHER  Did you ever experience similar symptoms prior to the accident? □YES □NO  Has your condition □IMPROVED □ WORSENED or □STAYED SAME since the accident?  Is your condition affecting your □ WORK □SLEEP or □DAILY ROUTINE? Please explain □  Please indicate your degree of difficulty (on a scale of 1-10, with 1 being comfortable, 5 being uncomfortable, and 10 being painful) in performing the following activities: □ Lying on Back □ Lying on Side □ Lying on stomach □ Sitting □ Standing □ Stretching □ Lovemaking □ Walking □ Running □ Sports □ Working □ Lifting □ Bending □ Kneeling □ Pulling □ Reaching  How many hours are in your normal workday? □ □				
Did you ever experience similar symptoms prior to the accident?    YES   NO				
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Has your condition   IMPROVED   WORSENED or   STAYED SAME since the accident? Is your condition affecting your   WORK   SLEEP or   DAILY ROUTINE? Please explain		similar symptoms prior to the a	ccident? ¬VES ¬	NO.
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Running Sports Working Lifting Bending Kneeling Pulling Reaching How many hours are in your normal workday?				
Bending Kneeling Pulling Reaching How many hours are in your normal workday?				
How many hours are in your normal workday?		Sports	Working	Liftina
ACC Form		Kneeling		
		Kneeling		

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TWISTING		our daily job duties an	그리고 그러지 않아 있다고 하는 가게 되고 있는 것이 없는 것이 없다.	프로그리스 경기 사람들이 있다면 내가 있었다. 그 사람들은 그리고 그리고 말했다.	
TYPING					□SITTING
What positions can you work in with minimum physical effort, and for how long?  Do you work with others who can help you with any heavy lifting?			MS ABOVE HEAD		
Do you work with others who can help you with any heavy lifting?		□LIFTING		□BENDING	□STOOPING
Do you work with others who can help you with any heavy lifting?	What positions ca	an vou work in with mi	nimum physical effo	rt, and for how long?	
While in recovery, are there any light duty tasks you could request?		-			
Health History  Have you ever had any of the following diseases or conditions?    HEART ATTACK or STROKE	-				
Have you ever had any of the following diseases or conditions?    HEART ATTACK or STROKE	•	, , , ,		-	
CONGENITAL HEART DEFECT	Have you ever ha	ad any of the following			
ALCOHOL/DRUG ABUSE	□HEART ATT	ACK or STROKE	☐HEART SURGE	RY or PACEMAKER	☐HEART MURMUR
HIV/AIDS	<b>□CONGENITA</b>	L HEART DEFECT	<b>□MITRAL VALVE</b>	COLLAPSE	□ARTIFICIAL VALVES
FREQUENT NECK PAIN	□ALCOHOL/D	RUG ABUSE	□VENEREAL DIS	EASE	<b>□HEPATITIS</b>
HIGH/LOW BLOOD PRESSURE	□HIV/AIDS		SHINGLES		<b>□CANCER</b>
SEVERE/FREQ. HEADACHES □FAINTING/SEIZURE/EPILEPSY □DIABETES □DIFFICULTY BREATHING □TUBERCULOSIS □LOWER BACK PROBLEMS □ARTIFICIAL BONES/JOINTS □ARTHRITIS  Please list any other medical conditions that you have or have ever had. □Please list any allergies. □Please list previous surgeries and dates. □Please list any past motor vehicle accidents or traumas and □Is there anything else about your health history or family health history that you feel is important to share? □Do you exercise? □YES □NO Are you on a special diet? □YES □NO Since:	□FREQUENT	NECK PAIN	<b>□EMPHYSEMA</b>		□ANEMIA
□FAINTING/SEIZURE/EPILEPSY □DIFFICULTY BREATHING □TUBERCULOSIS □LOWER BACK PROBLEMS □ARTIFICIAL BONES/JOINTS □ARTHRITIS  Please list any other medical conditions that you have or have ever had. □  Please list any allergies. □  Please list any past motor vehicle accidents or traumas and □  Is there anything else about your health history or family health history that you feel is important to share? □  Do you exercise? □ YES □ NO Are you on a special diet? □ YES □ NO Since:	□HIGH/LOW E	BLOOD PRESSURE	□PSYCHIATRIC F	ROBLEMS	□RHEUMATIC FEVER
DIABETES DIABETES DIFFICULTY BREATHING DATHING DATHING DIFFICULTY BREATHING DATHING DATHING DIFFICULTY BREATHING DATHING DATHING DIFFICULTY BREATHING DATHING DAT	□SEVERE/FRI	EQ. HEADACHES	<b>□KIDNEY PROBL</b>	EMS	□ULCERS/COLONITIS
Do you exercise?   YES   NO Since:   /   Do you smoke?   YES   NO How long?   HeEL LIFTS   ARCH SUPPORTS  For women: Are you taking birth control?   YES   NO How long?   Nursing?   YES   NO Are you pregnant?   YES   NO How long?   Nursing?   YES   NO Patient/Legal Guardian Signature   Date   Date   No How long?   No How long?   Date   No How long?   No How long?   Date   Date   Date	□FAINTING/SI	EIZURE/EPILEPSY	<b>□SINUS PROBLE</b>	MS	□ASTHMA
Please list any other medical conditions that you have or have ever had.  Please list any allergies.  Please list previous surgeries and dates.  Please list any past motor vehicle accidents or traumas and  Is there anything else about your health history or family health history that you feel is important to share?  Do you exercise?   YES   NO   NO   Since:       Do you smoke?   YES   NOHow much?   How long?   How long?   Are you wearing:   ORTHOTICS   HEEL LIFTS   ARCH SUPPORTS  For women:   Are you taking birth control?   YES   NO   NO   Nursing?   YES   NO   Are you pregnant?   YES   NO   How long?   Nursing?   YES   NO   Patient/Legal Guardian Signature   Date   Date	<b>□DIABETES</b>		□DIFFICULTY BR	EATHING	□TUBERCULOSIS
Please list any allergies.  Please list previous surgeries and dates.  Please list any past motor vehicle accidents or traumas and  Is there anything else about your health history or family health history that you feel is important to share?  Do you exercise?	□LOWER BAC	CK PROBLEMS	□ARTIFICIAL BO	NES/JOINTS	<b>□ARTHRITIS</b>
Please list previous surgeries and dates.  Please list any past motor vehicle accidents or traumas and  Is there anything else about your health history or family health history that you feel is important to share?  Do you exercise?					
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Is there anything else about your health history or family health history that you feel is important to share?  Do you exercise?	Ø -				
Do you exercise?   YES   NO   Are you on a special diet?   YES   NO Since:	Please list any pa	ast motor vehicle accid	lents or traumas and	<u> </u>	
Are you on a special diet?   YES NO Since: / /  Do you smoke?  YES NOHow much? How long?  Are you wearing:  ORTHOTICS HEEL LIFTS ARCH SUPPORTS  For women: Are you taking birth control?  YES NO How long? Nursing?  YES NO How long?  Patient/Legal Guardian Signature  Date				alth history that you	feel is important to
Are you pregnant?	Are you on a spe Do you smoke?	cial diet? □ YES □ I □ YES □ NOHow m	NO Since: / / uch? HEEL LIFTS □ AR	How long?	
					□ YES □ NO
	Patient/Legal Gu	uardian Signature		Date	
					ACC Form

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