

PERSONAL INJURY INTAKE

Name: _____ Birth Date: _____ Age: _____ Sex: M or F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Drive License #: _____ Social Security #: _____ Marital Status: _____
Occupation: _____ Employer: _____ Years Employed: _____
In Case of Emergency, Please Contact: _____ Phone: _____ Relation: _____

Please fill out personal insurance info, if applicable and hand insurance card to the receptionist for copy:

Your insurance Company: _____ Policy#: _____ Agent's Name: _____
Insurance Company Phone: _____ insurance Claim #: _____
Name on Policy (if other than yourself): _____ Policy #: _____

Please fill out responsible party's insurance info, if applicable:

Responsible Party's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Responsible Party's Insurance Carrier: _____ Phone: _____
Responsible Party's Policy #: _____ Claim #: _____

Information about your attorney:

Attorney Name: _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Were there any witness? () Yes () No

Information about your accident

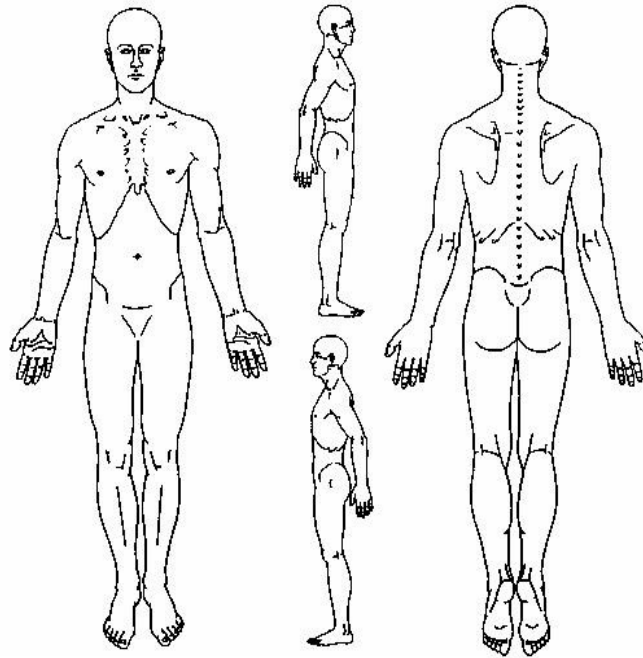
1. Date of accident: _____ Time of Day: _____
2. Were you: () Driver () Passenger () Front Seat () Back Seat
3. Were you wearing seat belt? () Yes () No
4. Number of people in your vehicle? _____
5. What direction was you headed? () North () South () East () West
on (the name of the street or freeway): _____
6. What direction was the other vehide headed? () North () South () East () West
7. Approximate speed of your car: _____ mph. Other vehicle: _____ mph.

8. Were you knocked unconscious? () Yes () No If yes, for how long? _____
9. Were police notified? () Yes () No If yes, were there a police report? () Yes () No
10. In your own words, please describe the accident: _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No
- If yes, please describe: _____

12. Please describe how you felt:
- a. During the accident: _____
 - b. IMMEDIATELY AFTER the accident: _____
 - c. LATER ON THAT DAY: _____
 - d. THE NEXT DAY: _____

13. Please mark X on the pictures where you have pain or symptoms:



14. What are your PRESENT complaints and symptoms?
- _____
- _____
- _____
- _____

15. Do you have any previous illnesses which relate to this case? () Yes () No

If yes, please describe: _____

16. Have you ever been involved in an accident before? () Yes () No

If yes, please describe, including date(s) and type(s) of accident(s) as well as injuries received:

17. Where were you taken after your current accident? _____

18. Have you been treated by another doctor since the accident? () Yes () No

If yes, please provide doctor name(s): _____

19. Since this injury occurred, are the symptoms () Improving () Getting worse () Same

20. Have you lost time from work as a result of this accident? () Yes () No

a. Last day worked: _____

b. Type of employment: _____

c. Present salary: _____

d. Are you being compensated for time lost from work? () Yes () No

If yes, type of compensation you are receiving: _____

21. Do you notice any activity restrictions as a result of this injury? () Yes () No

If yes, please describe: _____

22. Are you seeing any other physicians for any other conditions at this time? () Yes () No

If yes, please explain: _____

I agree to the following: All services rendered to me are charged directly to me and that I am personally responsible for payments. If I suspend or terminate my care and treatment, fees for services rendered to me will be immediately due and payable. All cancellations must be made 24 hours in advance. "No Show" and Late Cancellation will be assessed a \$20 fee.

Patient's Signature: _____ Date: _____