CONFIDENTIAL PATIENT INTAKE FORM

Date of Interview:_____

Referred By:_____

Patient's Name:_____

Address:_____

_____

Phone:_____(home)_____(work)_____(Mobile)

e-mail_____Fax_____

Date of Birth:_____SSN:_____Driver's License #:_____

Date of Accident:_____

Was anyone else in the collision with you:_____

Marital Status: S M D W Spouse's Name:_____

Dependents and Ages:_____

Height_____ Weight:_____ L/R Handed?_____

Facts of the Collision

Date:_____ Time:_____ Day of Week:_____

Weather (Sunny, Rainy, Snowing, Icy, etc.)_____

What Street did it happen on?_____County_____

Description of Accident / Event:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What type of vehicle were you in?_____

License plate number? _____ Who is the car's owner?_____

What type of vehicle was the other party driving:_____

Approximate speed – Your Vehicle: _____ Approximate speed – Other Vehicle _____

Your Driver's Foot Position (brake, clutch, both, neither, gas, etc.):_____

What parts of the car you were in were damaged?_____

Cost of repairing your car: $_____

Where did you get the damage estimate done?_____

Did either insurance company refer you to the garage who did the estimate or where the car was repaired? _____

Were you paid for the vehicle damage? ❑ Yes ❑ No How much? _____

Where did you get the vehicle repaired?_____

Patient's Insurance Company:_____

Address:_____

Adjustor:_____

Phone:_____Claim Number_____

PIP Policy Limits:_____ (UM/UIM)_____

Medical Insurance:_____

Did the Police Arrive? ❑ Yes ❑ No Which Police Department?_____

Police Officer's Name_____ Was Anyone Cited?_____

Statements made at the scene by you or other party:_____

_____

Have you made any statements to any insurance company or anyone else:_____

Do you, or anyone else, have photographs of the accident scene, automobiles or your injuries? ❑ Yes ❑ No

If so, who?_____

Were any vehicles towed from the scene? ❑ Yes ❑ No Who's vehicle was towed? ❑ Mine ❑ Other Drivers

Information on Other Driver

Driver:_____Owner_____

Was this a company vehicle? ❑ Yes ❑ No Company Name:_____

Driver's Address:_____

Phone Number:_____ Date of Birth:_____

Drivers License:_____ License Plate Number:_____

Company/Owner's Address:_____

Phone Number:_____ State of Incorporation:_____

Driver's Insurance Company:_____

Adjustor:_____

Address:_____

Phone:_____ Claim Number:_____

Damage to their car_____Estimated cost of Repair_____

Do you believe that any of the following were defective and resulted in either the accident itself or a worsening of your injuries? ❑ Road Signs ❑ Roads ❑ Traffic signal ❑ Brakes ❑ Seat belt ❑Airbag ❑Seat

Injuries, Impairment & Damages

Injuries as a result of the Accident / Event:_____

_____

_____

_____

_____

_____

Which of the following do you suffer from now, which you did not prior to the accident:

❑ Headaches	❑ Dizziness	❑ Difficulty Concentrating
❑ Long Term Memory Loss	❑ Short Term Memory Loss	❑ Amnesia
❑ Loss of Consciousness at Scene	❑ "Blackouts" Since Collision	❑ Forgetting ATM or other Numbers
❑ Reading Problems	❑ Writing Problems	❑ Typing Problems
❑ Apathy	❑ Irritability	❑ Sleep Disturbances
❑ Personality Changes	❑ Emotional Difficulties	❑ Relationship Difficulties
❑ Blurred Vision	❑ Photophobia (Sensitivity to Light)	❑ Vision Changes
❑ Intolerance to Alcohol	❑ Intolerance to Heat	❑ Intolerance to Cold
❑ Impaired Comprehension	❑ Impaired Learning	❑ Attention Impairment
❑ Loss of Libido	❑ Missing Periods of Time	❑ Speech Difficulties
❑ Concussion in Collision	❑ Nausea	❑ Vomiting
❑ Extreme Thirst Since Collision	❑ Fatigue	❑ Menstrual Irregularities
❑ Tinnitus (Ringing of Ears)	❑ Noise Intolerance	❑ Loss of Coordination
❑ Bumping Into Objects in View	❑ Loss of Balance	❑ Fluid in Ears
❑ Hearing Loss	❑ Vertigo (Spinning Sensation)	❑ Increased Symptoms in Crowds
❑ Anxiety	❑ Depression	❑ Change in Personality
❑ Flashbacks to Accident Scene	❑ Intrusive Thoughts of Accident	❑ Nightmares Since Collision
❑ Unusual Behavior Since Collision	❑ Social Withdrawal	❑ Panic Attacks
❑ Thoughts of Death /Suicide	❑ Weight Loss / Gain _____lbs	❑ Loss of Taste / Smell
❑ Blackouts with Neck Movements	❑ Dizziness with Neck Movements	❑ "Clunk" Sound w/ Moving Neck
❑ Jaw Pain	❑ Clicking in Jaw	❑ Pain with Chewing

Numbness / tingling / weakness in arms? Yes No R L Level(s)_____

Numbness / tingling / weakness in legs? Yes No R L Level(s)_____

Seatbelt: _____Did the Seatbelt bruise you? ❑Yes ❑No Where?_____

Head / Body position: ❑ Straight ❑ Right Rotated ❑ Left Rotated ❑ Up ❑ Down

Was the type of impact of the vehicles: ❑ Head On ❑ Right Side ❑ Left Side ❑ Oblique angle ❑ Rear End

Where was headrest located before impact? ❑ Upper Back ❑ Mid Neck ❑ Mid Head ❑ Upper Head ❑ None

Did your head or body strike anything inside the car? ❑ Yes ❑ No If so, what?_____

Did you lose consciousness? ❑ Yes ❑ No Did items in the car get displaced? What?_____

Did your Airbag(s) Deploy? ❑ Yes ❑ No Did your seats break? ❑ Yes ❑ No

Ambulance Companies:

	Company	Date	From	To
1.				
2.				

Hospitalizations or Outpatient Surgeries (Related only to this Collision):

	Physician	Facility	When	Problems?
1.				
2.				
3.				
4.				

Treating Physicians / Specialists / Therapists (Related only to this Collision):

	Provider /Facility	Address	Phone
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

What are you not able to do anymore as a result of this accident:_____

_____

Impaired Activities

Circle all activities which have been impaired in any way by the accident in question:

Daily Activities

bathing/showering	bending	brushing teeth	Dressing	driving car
vacationing	dining out	movie going	standing	sitting
sexual relations	lifting	church events	child care	religious activities (bending/kneeling)
shampooing hair	eating	Moving	reading	shaving
shopping	watching TV	sleeping	traveling	social events

Domestic Activities (Activities within the Home)

Bending	Cooking	ironing	housecleaning	laundry
Washing Dishes	vacuuming	dusting	interior painting	decorating

Household Activities (Activities outside the Home)

Trimming bushes	Gardening	Tree trimming	Mowing Lawn	Yard Work
Exterior painting	Car Washing	Landcaping	House Maintenence	Farm activities

Work Activities

Sitting	standing	lifting	using telephone	computer work
Reading	bending	typing	writing	child care

Hobby Activities

Aerobic exercise	archery	backpacking	bowling	badminton
baseball	basketball	basketry	bicycling	Boxing
card playing	camping	dancing	fencing	Fishing
flying	football	gardening	golf	Handball
gymnastics	health clubs	hockey	hunting	Judo
horseback riding	ice skating	Karate	painting	Yoga
jogging/running	photography	raquetball	rafting	sailing
mountain climbing	sewing	snow skiing	swimming	walking
musical instruments	volleyball	water skiing	water sports	weight lifting

Activities which you have performed despite pain, due to financial, family or personal needs (Duties Under Duress):

❑ Work ❑ Education ❑ Domestic (Activities within the Home) ❑ Household (Duties outside the Home)

_____

Past Motor Vehicle Accidents, Workers Compensation Claims, or other claims of Any Sort:_____

_____

_____

_____

_____

_____

Prior Medical History

Who is your regular doctor? Name:_____

Address:_____ Phone:_____

Please list all other past doctors or other health care providers (medical and alternative) you have seen and include their addresses, the dates or time periods in which you saw them, the reasons for seeing them, the types of treatment give to you, and whether they might have any information that would help us compare your present health with your health before the collision. (Excluding those noted above.)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

List, as carefully and accurately as you can, all injuries, illnesses, or medical conditions you have had in your life, even if they have no similarity to the injuries that you received in this collision. Include the approximate dates, the cause of the injuries, the doctors who treated you, and whether you fully recovered from these problems. If any lawsuit or claim was made for any of those injuries please so state.

_____

_____

_____

_____

_____

_____

Employment

Employer at Time of Loss:_____

Address:_____

Job Title:_____

Job Duties:_____

Additional Notes: