

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:

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

