

Personal Injury Intake Form

It is necessary that if your injuries are due to an automobile accident that we are given the following information within your first 2 visits or you may become responsible for continued charges. It is necessary to complete the following forms to best of your ability. Detail is imperative.

Insurance Name: _____ Phone Number: _____

Claim Address: _____

Claim Number: _____ Adjuster Name: _____

Patient Name: _____ Date of Accident: _____

Time: _____

Where did the accident happen? _____

Describe the accident in your own words:

What was your position in the car? Driver Passenger

If passenger, were you sitting in Front Right Rear Left Rear

Did your vehicle strike other vehicle? Yes No Was your car struck by other vehicle? Yes No

Was the impact from: the front from the right side from the left side from the rear

At the time of impact were you: looking straight ahead looking right looking left

Were both hands on the steering wheel? Yes No Was your foot on the brake? Yes No

Were you braced for impact? Yes No

Where in the car were you after the accident? _____

Were you wearing seat belts? Yes No Did you strike anything in the vehicle at the time of impact? Yes No

Please state part of body: Chest Chin Knee Shoulder Hand Head

Immediately following the accident how did you feel? _____

Were you unconscious? Yes No In a daze? Yes No

Did you go to the hospital? Yes No How did you get to the hospital? Ambulance Private Transportation

Did the ambulance attendants place you in: Neck Collar Yes No Splints Yes No Brace Yes No

Name of Hospital: _____

Attended by Dr. _____

Were you x-rayed at the hospital? Yes No

If Yes, what was the diagnosis? _____

Were you admitted to the hospital? Yes No How long did you stay? _____

What treatment was rendered? _____

What recommendations were made? See own doctor? Yes No See orthopedic doctor? Yes No

Physical Therapy? Yes No

Have you seen any other doctor as a result of this accident? Yes No

Doctor's Name: _____

Is your pain constant? Yes No Is the pain on and off? Yes No Sharp? Yes No

Dull? Yes No

Other: _____

Is your pain worse when arising from a chair? Yes No

Is it made worse by straining? Yes No By coughing? Yes No By sneezing? Yes No

By straining when moving your bowels? Yes No

Do you have any numbness or tingling in your arms? Yes No In your hands? Yes No

In your fingers? Yes No In your legs? Yes No In your feet? Yes No

In your toes? Yes No

What is your most comfortable position? Sitting Yes No Lying on your right side Yes No

Lying on your left side Yes No Lying on your back Yes No On your stomach Yes No

Standing Yes No

Other _____

Is it difficult for you to move around in bed? Yes No Does stretching and twisting worsen the pain? Yes No

Do any of the following relieve your pain? Heating pad Hot Bath Shower Ice pack

Does a brace (if you have tried one) help relieve the pain? Yes No

Does a change in heel height worsen the pain? Yes No

Do you feel better moving around? Yes No Or resting? Yes No

Do you have a firm mattress? Yes No

Do your knees ache or hurt? Yes No

Do you have cramps in your leg? Yes No In arm? Yes No

Have you had any change in your bowel habits? Yes No

Have you lots any time from work because of this accident? Yes No

If yes, give dates of time lost: From: _____ To: _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Before Your Accident, estimate your total lifting effort ability:

1. How much weight? Maximum Average
2. How far could you carry this weight? _____ For how long a period of time? _____
3. Was this lifting done at work? Yes No Or at home or elsewhere? Yes No
4. How often did you carry this amount of weight? _____

After Your Accident, describe your total lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort, or restriction of motion?

2. Did you experience this pain, discomfort or restriction of motion before your accident? Yes No
3. How far can you carry this weight now? _____ And for how long a period of time? _____
4. How often can you carry this weight? _____
5. Are you now limited in your lifting ability in some body position that you were previously not? Yes No
If so, specify position _____
6. What symptoms does lifting produce? _____
7. How long do these symptoms last? _____

Are you presently able to:

Lift: Very Heavy _____ lbs Heavy _____ lbs Light _____ lbs Sitting _____ lbs
Work: Very Heavy _____ lbs Heavy _____ lbs Light _____ lbs Sitting _____ lbs

What positions can you work in with a minimum demand of physical effort?

With minimum demand of physical effort, what positions can you work in part-time and for how long?

Standing Walking Sitting

With minimum demand of physical effort, can work in a sitting position with some degree of walking or standing activity? Yes No

Do you feel that you cannot perform any physical work activity? Yes No

Do you feel that you cannot perform any mental work? Yes No

Relate your before injury capacity (mark 'B') and your After injury capacity (mark 'A') for performing activities:

- | | | | | |
|--------------|--------------|---------------|-----------------|------------|
| 1. Walking | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 2. Standing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 3. Sitting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 4. Bending | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 5. Stooping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 6. Lifting | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 7. Pushing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 8. Pulling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 9. Climbing | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 10. Reaching | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 11. Gripping | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 12. Kneeling | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 13. Balance | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |
| 14. Fatigue | Normal _____ | Limited _____ | Difficult _____ | Pain _____ |

Generally speaking, is your inability to perform these functions due to Pain Weakness Structural limitations
 Nerves ?

Are you able to take care of your personal self, such as dressing, bathing, etc? Yes No or do you require assistance? Yes No

Do you feel your present condition is temporary? Yes No or permanent? Yes No

Vehicles Involved:

Your Vehicle – Year _____ Make _____ Model _____

Other Vehicle – Year _____ Make _____ Model _____

Accident Type: Rear ended Head-on Broad-sided Your Speed _____ Other Vehicle Speed _____

Damage to Your Vehicle: \$ _____ Other Vehicle Damage: \$ _____

Air bag deployed? Yes No

The Road was: Dry Wet Icy Snowy

The Weather Conditions were: Sunny Cloudy Foggy Light Rain Heavy Rain Snowing

Time of Day: Dawn Day Dusk Night Unknown

Other Doctors Seen: Orthopedist Psychiatrist Massage Therapist Neurologist

Physical Therapy Chiropractor

Any other information you would like to share with us:
