

# 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: \_\_\_\_\_

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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: \_\_\_\_\_

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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: \_\_\_\_\_

