Personal Injury Patient Information

Today's Date: _____ Date of Accident: _____

Patient Name: _____ SS#: _____

Home: _____ Cell:_____ Work:_____

E-Mail Address: _____ Driver License Number:_____

Address: _____City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Gender: ( ) M ( ) F Marital Status: M S W D

Spouse: _____ Birth Date: _____ Phone Number: _____

Past Medical History:

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail:

_____

_____

Have you had any major illnesses, injuries, falls or surgeries? Women, please include information regarding childbirth (include dates):_____

Do you have allergies to any medications? ( ) Y ( ) N If yes, please describe: _____

Have you ever seen a chiropractor before? ( ) Y ( ) N If yes, name of Dr. _____ Location: _____

Have you been treated for any health conditions in the last year? ( ) Y ( ) N

If yes, please describe: _____

Social History:

Do you drink alcoholic beverages? ( ) Y ( ) N If yes, how much per week? _____

Do you use any tobacco products? ( ) Y ( ) N Do you smoke? If so, packs per day: _____

Do you consume caffeine? ( ) Y ( ) N If yes, how much per day? _____

What are your hobbies? _____

What percent of time during the day do you spend: _____ lifting ____sitting ____bending _____at the computer?

What type of exercise do you perform? ( ) none ( ) light ( ) moderate ( ) strenuous

PRIMARY CARE PHYSICIAN Name: _____ Phone Number: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home: _____ Cell: _____ Work: _____

Auto Insurance:

Name of Company: _____ Name of Policy Holder: _____

Policy#_____ Agents Name: _____Agents Phone #:_____ Claim# _____

Liable Party's Auto Insurance Information:

Name of Company: _____ Phone :_____

Address: _____ City: _____ State: _____ Zip: _____

Policy Holders Name: _____ Policy #:_____ Claim #_____

Attorney:

Name: _____ Phone: _____ Fax#:_____

Address: _____City: _____ State: _____ Zip: _____

Name of Representative: _____ Phone: _____ Ext: _____ Claim #: _____

Witnesses: ( ) YES ( ) NO Name(s):_____

Nature of Accident:

1. Date of Accident: _____ Time of Day: _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? ( ) Yes ( ) No
4. Which direction were you heading? ( ) North ( ) South ( ) East ( ) West
5. What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
6. Name of street accident occurred on _____
7. Were you struck from: ( ) Behind ( ) Front ( ) Left Side ( ) Right Side
8. Approximate speed of your vehicle: _____mph Other Vehicle: _____mph
9. Were you knocked unconscious? ( ) Yes ( ) No
10. Were the police notified? ( ) Yes ( ) No
11. In your own words, please describe the accident: _____
    _____
    _____
12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY after the accident:_____
    c. LATER that day: _____
    d. The NEXT day: _____
13. What are your PRESENT complaints and/or symptoms? _____
    _____
    _____
14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No
    If yes, please describe: _____
15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
    If yes, please describe: _____

16. Did you seek treatment directly after the accident? If yes, name of hospital or urgent care. _____

_____

17. Have you been treated by another doctor since the accident? ( ) Yes ( ) No If yes, please provide doctors name(s) and contact information. _____
18. What type of treatment did you receive? _____
19. Did you have imaging services performed after the accident? ( ) X-Ray ( ) MRI ( ) CT Scan ( ) Other_____
20. Since this injury occurred are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

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21. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐Headaches	☐Irritability	☐Numbness in Toes	☐Face Flushed	☐Feet Cold
☐Neck Pain	☐Chest Pain	☐Shortness of Breath	☐Buzzing in Ears	☐Hands Cold
☐Neck Stiff	☐Dizziness	☐Fatigue	☐Loss of Balance	☐Stomach Upset
☐Sleeping Problems	☐Head Seems Too Heavy	☐Depression	☐Fainting	☐Constipation
☐Back Pain (mid or lower)	☐Pins & Needles in Arms	☐Light Bothers eyes	☐Loss of Smell	☐Cold Sweats
☐Nervousness	☐Pins & Needles in Legs	☐Loss of Memory	☐Loss of Taste	☐Fever
☐Tension	☐Numbness in Fingers	☐Ears Ring	☐Diarrhea	☐Other_____

22. Have you lost time from work as a result of this accident? ( ) Yes ( ) No
    If yes, please complete the following list of questions:
    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, please state the type of compensation you are receiving.
    _____
23. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe, in detail:
    _____
    _____
    _____
24. Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accident and/or injury. _____
    _____
25. Other pertinent information:_____
    _____
    _____

AUTHORIZATION AND RELAEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office of Porter & Rabinowitz Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

_____ _____ _____

Printed Name Signature Date