

Newport Massage Therapy

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Personal Injury Intake Form

Patient Information:

Today's Date _____

Name _____

I prefer to be called _____

Address _____

Cell Phone _____

Home Phone _____

Work Phone _____

Email _____

Social Security # _____

Date of Birth _____

Sex Male Female

Occupation _____

Employer _____

Address _____

If minor, name of parent or guardian _____

Who should we contact in case of an emergency? _____

Relationship _____

Address _____

Primary Care Physician _____

How did you hear about our office? _____

Have you ever been to a chiropractor before? YES NO If so, whom? _____

Height _____' _____" Weight _____ lbs _____

Marital Status _____

of Children _____

Phone _____

Phone _____

Health Insurance Information:

Insurance Company _____

Policy Holder's Name _____

Address _____

Policy Number _____

Social Security # _____

Phone _____

Auto Insurance Information:

Insurance Company _____

Address _____

Adjustor Name _____

Policy Number _____

Phone _____

Claim # _____

Accident Information:

Date _____ Time _____ AM PM

Was a traffic violation issued? YES NO

Location of accident (Street, Town) _____

Were there other witnesses? YES NO

Make/model of vehicle you were in _____

Please explain in detail how the accident occurred _____

Please list symptoms felt immediately after the accident _____

Was it reported to the police? YES NO

To whom?: _____

_____ # of other passengers _____

In which direction were you headed? N S E W Approx. speed of vehicle _____ MPH

Did the impact to your vehicle come from the: FRONT REAR RIGHT LEFT OTHER

During impact, were you facing: RIGHT LEFT FORWARD

Were you AWARE or SURPRISED by the impact?

Were you the DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER?

Were you wearing a seat belt? **SHOULDER HARNESS** **LAP HARNESS**
Was the vehicle equipped with air bags? **YES** **NO** Did they inflate? **YES** **NO**
In relation to the base of your skull, where was the headrest? **ABOVE** **BELOW** **AT**
BASE

What did your vehicle impact? **ANOTHER VEHICLE** **OTHER** _____

If another vehicle, what was the make/model? _____

In which direction were they headed? **N** **S** **E** **W** Approx. speed of vehicle _____ MPH

Did any part of your body strike anything in the vehicle? **YES** **NO** Describe _____

Were you knocked unconscious? **YES** **NO** If yes, for how long? _____

Damage to your vehicle: \$ _____ Other vehicle damage: \$ _____

Were you at fault? **YES** **NO** Do you have PIP? **YES** **NO**

Have you retained an attorney? **YES** **NO**

Attorney's Name: _____

Attorney's Phone: (____) _____ Fax: (____) _____

Attorney's Address: _____

City: _____ State: _____ Zip: _____

Post-Injury Information:

Have you seen any other doctor(s) since the accident? **YES** **NO** Name _____

When did you go? **IMMEDIATELY** **NEXT DAY** **2 DAYS PLUS**

How did you get there? **AMBULANCE** **PRIVATE TRANSPORTATION**

Name of hospital and/or attending doctor: _____

Was he/she a: **D.C.** **M.D.** **D.O.** **D.D.S.**

Please describe any treatment you received _____

Were X-Rays done? **YES** **NO** An MRI? **YES** **NO** CT scan? **YES** **NO**

Was medication prescribed? **YES** **NO** If yes, what? _____

Have you missed any work since the accident? **YES** **NO** Date(s) _____

Are your work activities restricted as a result of your injury? **YES** **NO**

Indicate the symptoms that are a result of this accident:

- DIZZINESS** **DIFFICULTY SLEEPING** **JAW PROBLEMS** **NAUSEA**
- MEMORY LOSS** **ARM/SHOULDER PAIN** **IRRITABILITY** **BACK PAIN**
- HEADACHE(S)** **NUMB HANDS/FINGERS** **FATIGUE** **LOW BACK PAIN**
- BLURRED VISION** **TENSION** **CHEST PAIN** **BACK STIFFNESS**
- BUZZING IN EAR** **NECK PAIN** **SHORT BREATH** **LEG PAIN**
- EARS RINGING** **NECK STIFF** **STOMACH UPSET** **NUMB FEET/TOES**
- OTHER**

Did you ever experience similar symptoms prior to the accident? **YES** **NO**

Has your condition **IMPROVED** **WORSENERD** or **STAYED SAME** since the accident?

Is your condition affecting your **WORK** **SLEEP** or **DAILY ROUTINE**?

Please explain _____

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable and 5 being painful) in performing the following activities:

___ Lying on Back	___ Lying on Side	___ Lying on stomach	___ Sitting
___ Standing	___ Stretching	___ Lovemaking	___ Walking
___ Running	___ Sports	___ Working	___ Lifting
___ Bending	___ Kneeling	___ Pulling	___ Reaching

How many hours are in your normal workday? _____

Signature: _____ Date: _____