Newport Chiropractic Center PS
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Personal Injury Intake Form

Patient Information:

Today's Date__________________________ Cell Phone_____________________________
Name _________________________________ Home Phone____________________________
I prefer to be called____________________ Work Phone____________________________
Address _______________________________ Email_________________________________
_____________________________________ Social Security #_______________________
_____________________________________ Date of Birth___________________________

Sex **Male** **Female** Height ____' ____" Weight ______ lbs_____
Occupation ____________________________ Marital Status__________________________
Employer______________________________ # of Children__________________________
Address____
If minor, name of parent or guardian____
Who should we contact in case of an emergency?____
Relationship____________________________ Phone________________________________
Address____
Primary Care Physician__________________ Phone________________________________
How did you hear about our office?____
Have you ever been to a chiropractor before? **YES** **NO** If so, whom?___________________

Health Insurance Information:

Insurance Company _____________________ Policy Number__________________________
Policy Holder's Name ___________________ Social Security #________________________
Address _______________________________ Phone________________________________

Auto Insurance Information:

Insurance Company _____________________ Policy Number__________________________
Address _______________________________ Phone________________________________
Adjustor Name__________________________ Claim #_______________________________

Accident Information:

Date _____________ Time ________ AM PM Was it reported to the police? **YES** **NO**
Was a traffic violation issued? **YES** **NO** To whom?:______________________________
Location of accident (Street, Town)___________________________ # of other passengers______
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_________________________________
____
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** **WORSENED** 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:____________________