Newport Chiropractic Center PS
4307 Factoria Blvd SE Suite 1
Bellevue, WA 98006-1936
425.747.5657

Dr. John P. Lorge III DC
Dr. Carly Roberts DC

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:_____