

PLEASE PROVIDE US WITH THE FOLLOWING PERSONAL AND OTHER PERTINENT INFORMATION REQUESTED

Today's Date: _____
 Name: _____
 Date of Birth: _____
 Mailing Address: _____
 City/State/ZIP: _____
 Occupation: _____
 Employer: _____
 Employer's Address: _____
 City/State/ZIP: _____

Nickname Preferred: _____
 Male Female
 Social Security #: _____
 Home Phone: () _____
 Work Phone: () _____

Were you referred by: Yourself Friend Insurance Carrier Primary Physician Other Physician

FINANCIAL	YOUR AUTO INSURANCE CARRIER	YOUR MAJOR MEDICAL CARRIER
NAME		
ADDRESS		
CITY/ST/ZIP		
POLICY #		
INSURED NAME		
OTHER FINANCIAL	OTHER DRIVERS INSURANCE CARRIER	YOUR ATTORNEY
NAME		
ADDRESS		
CITY/ST/ZIP		
POLICY #		Phone: _____
INSURED NAME		Fax: _____

Please describe the accident in your own words: _____

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

 Signature

 Date

Date of Accident: _____ Time of Accident: _____ Was A Police Report Filed? No Yes

Involving: Car Taxi Van Truck Motorcycle Bus Other

Were you: Driver Passenger [] Front [] Back Pedestrian Riding a Bicycle

Were you struck from: Front Behind Left Right Left Oblique Right Oblique

Did you strike: Window Door Dash Steering Wheel Were you wearing a seat belt? No Yes

Did you hit your head? No Yes Did you lose consciousness? No Yes How long? _____

Were you taken to the hospital? No Yes [] By ambulance [] By relative [] Drove myself

Name of hospital and address: _____

Were you (please check all that apply):

Kept overnight Admitted for _____ days

X-rayed Treated cuts/bruises

Treated for fractures Examined and released

Examined and released with medications

Advised to follow up with my own physician on next day

Have you ever been in an accident before? No Yes

When / Where? _____

What problems are you having today?

ON THE FIGURES AT RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

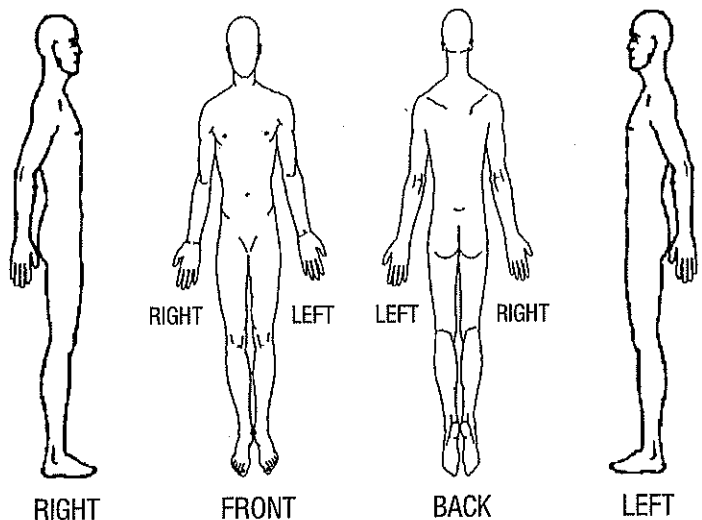
- +++ Burning /// Stabbing
 ●●● Pins & Needles XXX No Feeling

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain, to 10 being very severe, how severe is your pain in each area most of the time.

AREA 1 pain is (1-10) _____

AREA 2 pain is (1-10) _____

AREA 3 pain is (1-10) _____



Which words describes your pain MOST of the time?

Constant Tingling

On and off Burning

Occasional Throbbing

Only at night Deep, stabbing

Only on exertion Deep, achy

Dull ache Sharp recurring pain

How would you describe your current mobility?

Self-mobile Need walker

Need cane Need wheelchair

Which best describes your current employment?

Working Full time Part time

Unemployed

On sick leave

On temporary disability

On permanent disability

Retired

If on temporary or permanent disability or sick leave, last full day of work was: _____

_____ PATIENT ID# DATE

Date of Accident: _____ Time of Accident: _____ Was A Police Report Filed? No Yes

Involving: Car Taxi Van Truck Motorcycle Bus Other

Were you: Driver Passenger [] Front [] Back Pedestrian Riding a Bicycle

Were you struck from: Front Behind Left Right Left Oblique Right Oblique

Did you strike: Window Door Dash Steering Wheel Were you wearing a seat belt? No Yes

Did you hit your head? No Yes Did you lose consciousness? No Yes How long? _____

Were you taken to the hospital? No Yes [] By ambulance [] By relative [] Drove myself

Name of hospital and address: _____

Were you (please check all that apply):

Kept overnight Admitted for _____ days

X-rayed Treated cuts/bruises

Treated for fractures Examined and released

Examined and released with medications

Advised to follow up with my own physician on next day

Have you ever been in an accident before? No Yes

When / Where? _____

What problems are you having today?

ON THE FIGURES AT RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT.

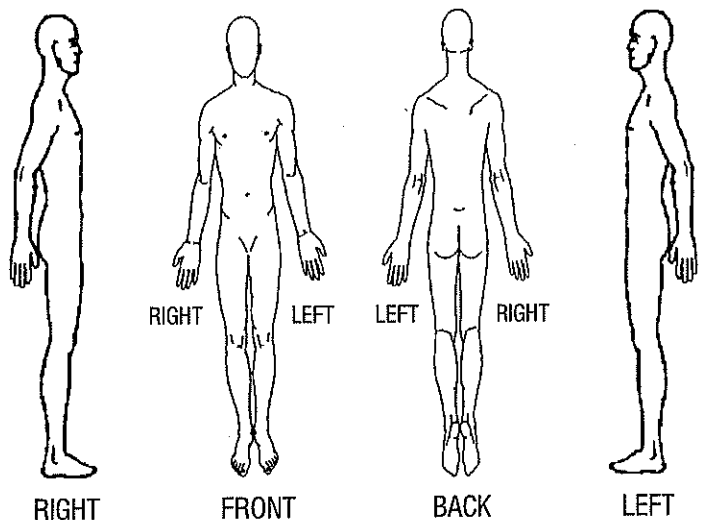
- +++ Burning /// Stabbing
 ●●● Pins & Needles XXX No Feeling

Circle the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain, to 10 being very severe, how severe is your pain in each area most of the time.

AREA 1 pain is (1-10) _____

AREA 2 pain is (1-10) _____

AREA 3 pain is (1-10) _____



Which words describes your pain MOST of the time?

Constant Tingling

On and off Burning

Occasional Throbbing

Only at night Deep, stabbing

Only on exertion Deep, achy

Dull ache Sharp recurring pain

How would you describe your current mobility?

Self-mobile Need walker

Need cane Need wheelchair

Which best describes your current employment?

Working Full time Part time

Unemployed

On sick leave

On temporary disability

On permanent disability

Retired

If on temporary or permanent disability or sick leave, last full day of work was: _____

_____ PATIENT ID# _____ DATE _____