



Personal Injury Intake Form

File Number (Office Use) _____

Patient Information:

Today's Date _____

Name _____

I prefer to be called _____

Address _____

Sex Male Female

Occupation _____

Employer _____

Address _____

If minor, name of parent or guardian _____

Who should we contact in case of an emergency? _____

Relation _____

Address _____

Attorney _____

Primary Care Physician _____

How did you hear about our office? _____

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

Home Phone _____

Work Phone _____

Email _____

Social Security # _____

Date of Birth _____

Height ____' ____" Weight _____ lbs

Marital Status _____

No of Children _____

Accident Information:

Date _____ Time _____ AM PM

Was a traffic violation issued? YES NO

Location of accident (Street, Town) _____

Were there other witnesses? YES NO

Please explain in detail how the accident occurred _____

Was it reported to the police? YES NO

To whom? _____

of other passengers _____

Make/model of vehicle you were in _____

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? _____ Direction _____ Speed _____ MPH
Did any part of your body strike anything in the vehicle? **YES** **NO** Describe _____
Did the accident render you unconscious? **YES** **NO** If yes, for how long? _____

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** CAT 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:

<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> DIFFICULTY SLEEPING	<input type="checkbox"/> JAW PROBLEMS	<input type="checkbox"/> NAUSEA
<input type="checkbox"/> MEMORY LOSS	<input type="checkbox"/> ARM/SHOULDER PAIN	<input type="checkbox"/> IRRITABILITY	<input type="checkbox"/> BACK PAIN
<input type="checkbox"/> HEADACHE(S)	<input type="checkbox"/> NUMB HANDS/FINGERS	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> LOW BACK PAIN
<input type="checkbox"/> BLURRED VISION	<input type="checkbox"/> TENSION	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> BACK STIFFNESS
<input type="checkbox"/> BUZZING IN EAR	<input type="checkbox"/> NECK PAIN	<input type="checkbox"/> SHORT BREATH	<input type="checkbox"/> LEG PAIN
<input type="checkbox"/> EARS RINGING	<input type="checkbox"/> NECK STIFF	<input type="checkbox"/> STOMACH UPSET	<input type="checkbox"/> NUMB FEET/TOES
<input type="checkbox"/> 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? _____
Please indicate your daily job duties and any activities that you are occasionally asked to perform:

<input type="checkbox"/> STANDING	<input type="checkbox"/> OPERATING EQUIPMENT	<input type="checkbox"/> DRIVING	<input type="checkbox"/> SITTING
<input type="checkbox"/> TWISTING	<input type="checkbox"/> WORK W/ARMS ABOVE HEAD	<input type="checkbox"/> WALKING	<input type="checkbox"/> CRAWLING
<input type="checkbox"/> TYPING	<input type="checkbox"/> LIFTING	<input type="checkbox"/> BENDING	<input type="checkbox"/> STOOPING

What positions can you work in with minimum physical effort, and for how long? _____
Do you work with others who can help you with any heavy lifting? **YES** **NO**
While in recovery, are there any light duty tasks you could request? **YES** **NO**

Auto Insurance Information:

Insurance Company _____ Policy number _____
Address _____ Phone _____
Adjustor Name _____ Claim # _____

Patient Signature _____ **Date** _____



Office Policies

The following are Palm Beach Family Chiropractic & Sports Medicine's office policies. Please read carefully, and be sure to ask any questions you might have before signing the document.

Consent for Treatment. I, the undersigned, give Palm Beach Family Chiropractic & Sports Medicine my permission to evaluate and treat my injury. I further understand that, in the course of recommended treatment, conditions may worsen on rare occasions. I further understand that **no guarantee or promise** has been made to me concerning the results of treatment.

Appointment Scheduling. Kindly give 24 hours notice if you are unable to keep a scheduled appointment. We reserve the right to charge \$25 for missed appointments without prior notice.

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments.) It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my health insurance policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office. In the rare event it is necessary to send your account to collections and/ or an attorney for collections, you agree for it to be handled in Palm Beach County in the State of Florida, and to pay for any attorney fees that may be necessary.

Patient/Parent or Legal Guardian Signature _____ **Date** _____



PALM BEACH
FAMILY CHIROPRACTIC
& SPORTS MEDICINE

Assignment of Insurance Benefits

Patient Name: _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Palm Beach Family Chiropractic & Sports Medicine, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Palm Beach Family Chiropractic & Sports Medicine.

Furthermore, I hereby IRREVOCABLY ASSIGN to Palm Beach Family Chiropractic & Sports Medicine, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the state Florida statutes for any service and or charges provided by Palm Beach Family Chiropractic & Sports Medicine.

Signature of witness: _____

Signature of patient or responsible party: _____



PALM BEACH
FAMILY CHIROPRACTIC
& SPORTS MEDICINE

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____ have read a copy of **Palm Beach Family Chiropractic & Sports Medicine's** notice of Patient Privacy Practices.
Patient Name

Signature of patient or parent or legal guardian

Date