PERSONAL INJURY INTAKE FORM

****The information you provide in this intake form will be used by insurers to evaluate your insurance benefits, as well as any other benefits you may be eligible for, so it is very important that it is accurate, detailed, and fully complete****

Personal Data

Today's Date: Date of Accident:

Name: Age: DOB: Sex: ☐ M ☐ F

Address:

City State: Zip:

Cell Phone: SSN: Driver's Lic. #:

Email:

Are you/ have you been disabled from work?

Who can we thank for refering you:

In Case of Emergency, notify:

Relationship: Phone:

Auto Insurance Information

Who is the insured person on your policy?

Name of your insurance company:

Address:

City: State: Zip:

Insurance Company Phone #: Policy #:

Accident Claim #: Who was at fault (name)?:

Have you contacted an insurance adjuster or representative reguarding this claim? Yes No

If Yes, Adjuster's name: Adjuster Phone #:

Is there Medical Payments (MedPay) coverage? ☐ Yes ☐ No What is the MedPay limit?

Have you filed an injury report? ☐ Yes ☐ No

Other Party's Insurance (if applicable)

Insurance Company:

Address:

City: State: Zip: Phone #:

Policy #: Claim #:

Additional Insurance (if applicable)

Do You have additional insurance? Yes No Company:

Name of the Insured: Relationship to Patient:

DOB: SSN: Date Employed:

Address:

City: State: Zip: Phone #:

Policy #: Claim #:

PERSONAL INJURY INTAKE FORM

Vehicle Accident Information

Accident Site

City/State:

Speed you were traveling:

Speed other car was traveling:

Make and model of your car:

Make and model of other car:

Police

Were there any witnesses? ☐ No ☐ Yes

Was a police report filed? ☐ No ☐ Yes

Did an ambulance come? ☐ No ☐ Yes

Did you go to the hospital? ☐ No ☐ Yes

Accident Info

Were you wearing a seatbelt? ☐ No ☐ Yes

Wasthe vehichle equipped with airbags? ☐ No ☐ Yes

Did the airbags deploy? ☐ No ☐ Yes

Was the Car totaled? ☐ No ☐ Yes

Didyou lose consciousness? ☐ No ☐ Yes

Did your body hit anything? ☐ No ☐ Yes

If yes, explain:

Attorney

Have you engaged the services of an attorney? Yes No

Attorney:

Address:

City: State: Zip:

Phone #: Fax #:

Work & This Injury

Have you missed work due to this accident/injury? Missed no work Limited work activity

Missed work from: To:

Last day worked: Type of employment:

Injury Details

Did the impact to our vehichle come from the: ☐ Front ☐ Left ☐ Right ☐ Other

During the impact were you facing: ☐ Left ☐ Right ☐ Forward

Were you aware or surprised by the impact? ☐ Aware ☐ Surprised

Were you the: ☐ Driver ☐ Front Passenger ☐ Back Passenger

Were you wearing a seatbelt? ☐ Shoulder Harness ☐ Lap Harness ☐ No

Was the vehichle 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 vehichle impact? ☐ Another vehichle
☐ Other:

If another vehichle, what was the make/model: Direction: Speed:

Did any part of your body strike anything in the vehichle? ☐ No
☐ Yes, describe:

Did the sccident render you unconcious? ☐ No
☐ Yes, how long?

PERSONAL INJURY INTAKE FORM

For This Injury

Did you go to the hospital or urgent care? ☐ Yes ☐ No

If so, when did you go? ☐ Immediately ☐ Next Day ☐ After 2 or more days

How did you get to the hospital/UC? ☐ Ambulance ☐ Private Transportation

Name of Hospital: Name of Doctor:

Diagnosis:

Treatment Received:

X-ray/CT/MRI taken: ☐ Yes ☐ No

Body Parts:

Did you self treat your symptoms? ☐ Ice ☐ Heat ☐ Over the Counter Medication
Other:

If there were lacertations (cuts), where were they?

Current Complaints

Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

Check Symptoms you havenoticed since the accident:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Feet Cold	☐ Chest Pain	☐ Shortness of breath	☐ Face Flushed
☐ Neck Pain	☐ Hands Cold	☐ Buzzing in Ears	☐ Dizziness	☐ Fatigue	☐ Loss of Blance	☐ Head seems too heavy
☐ Neck Stiff	☐ Depression	☐ Fainting	☐ Constipation	☐ Back Pain	☐ Pins and needles in Arms/Legs	
☐ Lights bother eyes	☐ Foot Pain	☐ Sleeping problems	☐ Loss of smell	☐ Cold sweats	☐ Nervousness	☐ Loss of memory
☐ Loss of taste	☐ Fever	☐ Tension	☐ Ears ringing	☐ Diarrhea	☐ Leg Pain	☐ Numbness in Fingers
☐ Arm Pain	☐ Back Stiffness	☐ Jaw Problems	☐ Nausea	☐ Blurred Vison	☐ Head Pain	☐ Shoulder Pain
☐ Midback Pain	☐ Low Back Pain					

Since your accident have you suppered from any of the following?

☐ Blurred vision	☐ double vision	☐ reduced vision	☐ impaired hearing	☐ ringing in ears	☐ chest pain	☐ difficulty breathing
☐ Palpitations	☐ Constipation	☐ Nausea	☐ Vomiting	☐ frequent urination	☐ inability to hold urine	☐ digestive troubles
☐ painful urination	☐ ED					

PERSONAL INJURY INTAKE FORM

Please complete this section of this form thoroughly.

In your own words, describe your injuries in detail. Be specific about the areas affected, the severity of each injury, and the exact location of any pain or symptoms.

If any of your injuries are visible, please note whether you have taken photographs for documentation.

What symptoms are you experiencing as a result of these injuries?
Please describe each symptom in detail, including how it feels, how frequently it occurs, and how it impacts your daily activities. Use your own words to explain the nature of the symptoms.
*On a scale from 1 to 10—where **1** means the symptom is barely noticeable and **10** means it requires hospitalization—please rate the severity of each symptom.*

When did you first begin experiencing symptoms related to your injuries?"

Have you attempted to self-treat any of these injuries? (For example: rest, heat, ice, over-the-counter medications, etc.) If so, please describe what you tried and whether it helped.

Have you ever sustained injuries to your body from a previous accident or incident?

If so, please provide details, including the nature of the injuries and when they occurred and if you were still being actively treated for these injuries? If you were not being actively treated when did the treatment stop.

Are there any activities you are currently unable to perform due to your injuries? If so, please list them. These may include activities related to work, home, or public settings.

Are there any activities you are still able to perform, but with limitations due to pain or other restrictions? If so, please list those activities and describe how they are limited.

Are there any specific activities that seem to exacerbate or worsen your injuries? If so, please list them.

Are there any activities, treatments, or routines that seem to improve your injuries or overall condition? If so, please describe them."

How would you best describe your general diet? (Select all that apply):

☐ Mostly whole, unprocessed foods (e.g., fresh vegetables, fruits, lean meats, whole grains)
☐ High in processed or packaged foods
☐ High in sugar or sweets
☐ High in fried or fatty foods
☐ Vegetarian or plant-based
☐ High in red meat
☐ Low in fruits and vegetables
☐ Skips meals regularly
☐ Eats fast food more than 3x per week
☐ Drinks sugary beverages or sodas regularly
☐ Drinks alcohol regularly
☐ Follows a specific diet (e.g., keto, paleo, intermittent fasting, etc.) — *Please specify:*
☐ Other — *Please describe:*

On average, how many meals do you eat per day?
☐ 1
☐ 2
☐ 3
☐ More than 3
☐ Varies

How much water do you typically drink per day?
☐ Less than 2 cups
☐ 2–4 cups
☐ 5–7 cups
☐ 8 or more cups
☐ Unsure

Doctors Notes:

Has your sleep been affected since sustaining your injuries?
☐ No, my sleep has not changed
☐ Yes, my sleep is now interrupted or disrupted

If yes, what issues are you experiencing? (Select all that apply):
☐ Difficulty falling asleep
☐ Waking up frequently during the night
☐ Pain wakes me up
☐ Difficulty finding a comfortable sleeping position
☐ Waking up feeling unrested
☐ Other — *Please describe:*

On average, how many hours do you sleep per night?
☐ Less than 4 hours
☐ 4–6 hours
☐ 6–8 hours
☐ More than 8 hours
☐ Varies from night to night

Doctors Notes:

Were you actively being treated for any medical conditions at the time of your injury?
☐ No
☐ Yes — *If yes, please complete the section below:*

Please list each condition, the treating doctor, and whether the condition has worsened since your injury.

Medical Condition	Treating Doctor/Clinic	Has Condition Worsened Since Injury?
		☐ Yes ☐ No ☐ Not Sure
		☐ Yes ☐ No ☐ Not Sure
		☐ Yes ☐ No ☐ Not Sure
		☐ Yes ☐ No ☐ Not Sure
		☐ Yes ☐ No ☐ Not Sure

Example:
Condition: Active Crohn's Disease
Doctor: Dr. Smith at Digestive Health Clinic
Worsened: Yes — experiencing increased flare-ups since the injury

If there are additional conditions, please list them here:

Doctors Notes:

How would you describe your general physical condition at the time of your recent injuries?

☐ Very fit and active
☐ In average shape
☐ Somewhat out of shape
☐ Significantly out of shape
☐ Other — *Please describe:*

Please explain in your own words what you feel your overall health and physical condition was like at the time of your injuries:

.
.
.
.
.

Were you engaged in any body conditioning or maintenance activities prior to your injury that have been interrupted or discontinued due to your condition?
(Examples: exercise, diet, weight loss programs, gym routines, cardio, stretching, etc.)

☐ No, I was not actively participating in any such activities
☐ Yes — *If yes, please describe below:*

Please describe the activities you were doing and how your injuries have impacted on your ability to continue them:

For Pregnant or Recently Pregnant Females Only:
At the time of your injury, were you:
☐ Pregnant
☐ Recently pregnant (within the last 12 months)
☐ Actively breastfeeding
☐ None of the above

If any of the above apply, please provide details (e.g., how far along you were in pregnancy, postpartum stage, breastfeeding frequency, etc.):

What is your personal goal for your injury recovery?
(For example: return to work, resume specific activities, reduce pain, regain strength or mobility, etc.)

Is there anything else you feel the doctor should know about your injuries, symptoms, or overall condition?
(Please use the space below to share any additional information that may help us better understand your situation.)

Additional consultation Notes (For Doctors Use Only)