NEW PATIENT INTAKE FORM
Personal Injury

PATIENT INFORMATION **CONFIDENTIAL**

Thank you for the opportunity to serve you. If you have any questions, do not hesitate to ask. We will be happy to help.

Name____ Date_____/_____/_____ S/S______-______-______
First MI Last
Address____ City_________________ State_____ Zip__________

Home Phone_________________________ Work Phone_________________________ Cell Phone_____________________

Birth Date_____/_____/_____ Height________ Weight________ e-mail address:______________________________

Sex: ❒ Female ❒ Male **Status:** ❒ Minor ❒ Married ❒ Single ❒ Other

Your Employer____ Occupation____________________________________

Business Address____ City_________________ State_____ Zip__________

Spouse/ Parent's Name____ Phone__________________

Who may we thank for referring you to us?____

Person to contact in case of an emergency____ Phone__________________

INSURANCE CO. ____ Policy # ______________________________________

Name on Policy (if not self) ____

Responsible Party's Name ____________________________________ Agent's name _________________________________

Address ____

ATTORNEY ____ Phone ____

Address ____

HEALTH HISTORY

Please check the following symptoms you have noticed **SINCE THE ACCIDENT** (❍) or **BEFORE THE ACCIDENT** (❒):

❍ ❒ Headaches
❍ ❒ Neck Pain
❍ ❒ Neck Stiffness
❍ ❒ Mid Back Pain
❍ ❒ Low Back Pain
❍ ❒ Arm Pain
❍ ❒ Leg Pain
❍ ❒ Pins and Needles in Arms
❍ ❒ Pins and Needles in Legs
❍ ❒ Numbness in Fingers
❍ ❒ Numbness in Toes
❍ ❒ Cold Hands
❍ ❒ Cold Feet
❍ ❒ Nervousness
❍ ❒ Tension
❍ ❒ Irritability
❍ ❒ Mood Swings
❍ ❒ Sleeping Problems
❍ ❒ Fatigue
❍ ❒ Depression
❍ ❒ Chest Pain
❍ ❒ Shortness of Breath
❍ ❒ Cold Sweats
❍ ❒ Fever
❍ ❒ Fainting
❍ ❒ Dizziness
❍ ❒ Loss of Balance
❍ ❒ Light Sensitivity with Eyes
❍ ❒ Ringing/ Buzzing in Ears
❍ ❒ Loss of Memory
❍ ❒ Loss of Smell
❍ ❒ Loss of Taste
❍ ❒ Upset Stomach
❍ ❒ Constipation
❍ ❒ Diarrhea
❍ ❒ Urinary Problems
❍ ❒ Heartburn
❍ ❒ Ulcers
❍ ❒ Allergies
❍ ❒ Menstrual Pain
❍ ❒ Menstrual Irregularity
❍ ❒ Hot flashes
❍ ❒ Other ______________
❍ ❒ Other ______________

Have **YOU** (❍) or **A FAMILY MEMBER** (❒) ever been diagnosed with any of the following conditions:

❍ ❒ AIDS/HIV
❍ ❒ Cancer
❍ ❒ High Blood Pressure
❍ ❒ Heart Disease
❍ ❒ Diabetes
❍ ❒ Stroke
❍ ❒ None
❍ ❒ Unknown
❍ ❒ Other ____________