



Milton Chiropractic & Rehabilitation, Inc.



BAY STATE PHYSICAL THERAPY

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 _____

Home Phone _____

Work Phone _____

Email _____

Social Security # _____

Date of Birth _____

Height ____' ____" Weight ____ lbs

Marital Status _____

No of Children _____

Health Insurance Information:

Insurance Company _____

Policy Holder's Name _____

Address _____

Policy number _____

Social Security # _____

Phone _____

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 _____

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:
 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** **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:
 STANDING **OPERATING EQUIPMENT** **DRIVING** **SITTING**
 TWISTING **WORK W/ARMS ABOVE HEAD** **WALKING** **CRAWLING**
 TYPING **LIFTING** **BENDING** **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** _____