Automobile Personal Injury Accident or Work Comp Intake Form

Patient Name _____Date of Birth _____Today's Date _____

Dear Patient: This information is considered confidential. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.

Please explain in detail how your accident happened._____

_____

_____

_____

_____

What was the time and date of present injury?_____

Where did you feel pain immediately after the accident?_____

List the extent of your injuries as you know them:_____

_____

_____

Did you require post accident hospitalization? Yes/No

Check symptoms you have noticed since the accident:

____Headache	____Dizziness	____Depression	____Fatigue
____Light Bothers Eyes	____Buzzing in Ears	____Diarrhea	____Neck Pain
____Head Seems too Heavy	____Memory Loss	____Feet Cold	____Neck Stiff
____Pins and Needles in Arms	____Ears Ring	____Hands Cold	____Fainting
____Numbness in Fingers	____Back Pain	____Face Flushed	____Loss of balance
____Shortness of Breath	____Constipation	____Tension	____Nervousness
____Sleeping Problems	____Loss of Smell	____Fever	____Irritability
____Cold Sweats	____Chest Pain	____Loss of Taste	____ Stomach Upset
____Pins and Needles in Legs	Symptoms other than above_____		

Patient's Name_____DOB_____Date_____

Where were you taken after the accident? _____

Hospitalized? Yes/No If yes, admitted? _____ How long? _____

Name of Hospital? _____ Name of Doctors_____

What treatment was given?_____

Was any other doctor consulted after your accident? Yes/No If so, doctor's name_____

What was the diagnosis?_____

What treatment was given?_____

How often did you see the doctor?_____ How long did you see the doctor?_____

Have you ever had any complaints in the involved area before? Yes / No If so what were the complaints?
_____

Before the injury were you capable of working on an equal basis with others your age? Yes / No

Are your work activities restricted as a result of this accident? Yes / No

Since this injury are your symptoms? Improving/ Getting Worse/ Same

Driver of other vehicle: Name_____Insurance Co_____

Policy #_____

Driver of vehicle in which you were injured (if applicable)

Name_____ Insurance Co _____Claim #_____

Name of your insurance adjustor_____

Adjustor contact phone number_____Fax number_____

Adjustor email address _____

Have you retained an attorney? Yes / No Is so, name _____address_____

You were headed North/East/South/West on _____(street or highway)

Other vehicle was heading North/East/South/West on _____(street or highway)

Were police notified? Yes / No Were you knocked unconscious? Yes / No If so, for how long?_____

You were struck from Behind/ Front/ Left Side/ Right Side_____

You were Driver/ Passenger/ Front Seat/ Back Seat/ using seat belts_____

Patient's Signature _____Date_____

Patient Name_____DOB_____Date_____

Please mark **P** for in the **Past**, **C** for **Currently** have, and **N** for **Never**

_____ Fractured Bones _____ Trouble Concentrating_____ Allergies _____ Sinus Problems

_____ Eating Disorders _____ Trouble Sleeping_____ Learning Disability_____ Mood Changes

_____ Headache_____ Pain/Stiff Neck R L _____ Accidents/Falls_____ Back Curvature

_____ Arthritis _____ Diabetes_____ Swollen/Painful Joints_____ Convulsions/Epilepsy

_____ Skin Problems_____ Cancer_____ Frequent Colds/Flu_____ Depressed

_____ Irritable _____ Anemia _____ Tremors

_____Numbness/Tingling/Pain Arms/Hands/Fingers R or L_____ Jaw Pain/TMJ R L_____ Head/Shoulders Feel Tired

_____ Difficulty in Excessive (Standing, Walking, Bending, Riding, Twisting, Lifting, Household Duties)

_____ Shoulder Pain R L_____ Dizziness _____ Ringing in Ears R L_____ Hearing Loss R L

_____ Fainting _____ Loss of Balance_____ Blurred Vision R L_____ Double Vision R L

_____ Upper Back Pain/Stiffness _____ Mid Back Pain/Stiffness _____ Low Back Pain/Stiffness

_____ Numbness, Tingling or Pain in buttocks, thighs, legs, feet, toes _____ Pain with cough, sneeze

_____ Hip Pain R L _____ Foot Trouble R L _____ Chest Pain _____ Asthma

_____ Lung Problems_____ Difficulty Breathing_____ Heart Problem_____ Stroke

_____ High/Low Blood Pressure _____ Varicose Veins _____ Liver Trouble

_____ Gall Bladder Trouble_____ Digestive Problems _____ Heartburn _____ Ulcers

_____ Diarrhea/Constipation _____ Colon Trouble _____ Hemorrhoids _____ Prostate Problems

_____ Impotence _____ Kidney Trouble_____ Menstrual Problem/PMS_____ Menopausal Problems

_____ Pregnant (now) _____ Bed Wetting _____ Ear Infection _____ AIDS/HIV

List Prescription and Non-Prescription drugs you take:_____

Irrevocable Assignment, Lien and Authorization Insurance Benefits and Attorney

To whom it may concern:

I hereby authorize and direct you, my insurance carrier and/or attorney to **pay directly** to **Beyond Innovation Chiropractic.** Such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and withhold such sums from any disability benefits, or any other insurance benefits obligated to reimburse me from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect Beyond Innovation Chiropractic. I hereby further give lien to said office against any and all insurance benefits named herein and any all proceeds of any settlement, judgment on verdict which may be paid to me as a result of the injuries or illness for which I have been treated for by **Beyond Innovation Chiropractic**. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Assignment, Lien, and Authorization do not constitute any consideration for the office to await payments, and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance carrier, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization.

I further understand and agree that if **Beyond Innovation Chiropractic** must take any action to collect an outstanding balance on this account, I will be responsible for payment of and will reimburse this office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

Dr. Mark Liebich

Patient Signature_____

Date _____