My Chiropractic Center
203 North Throop Street
Woodstock, IL. 60098

Todays date: ___/___/___

Personal Injury Intake Form

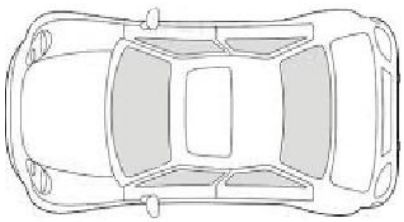
Patient Name: _____ Age: _____ Date of Birth _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone _____
Marital Status: _____ Number of Children: _____ Social Security #: _____
E-mail: _____

Employer: _____ Occupation: _____ Work Phone: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Can we send you e-mail newsletters? YES NO Can we send you office updates? YES NO

Date of Injury: ____/ _____/ _____ Location/City where Injury Occurred: _____
Was EMERGENCY MEDICAL assistance dispatched? YES NO Were the Police notified? YES NO
Were you hospitalized as a result of accident? YES NO Was a traffic violation issued? YES NO
Please Describe the accident:_____
_____
_____
Please describe any pains you felt after the accident : _____
_____
_____
* Did you have physical complaints prior to the date of THIS accident? YES NO
(If YES) Please describe the physical complaints prior to the accident in detail:_____
_____
_____
Is ANYTHING physically different with you AFTER the accident? YES NO
Describe the differences in detail: _____
_____
_____
_____
_____
Were you in a car/truck during the accident? YES NO (If YES) Which were you? Driver Passenger
Do you have legal council? YES NO
(If YES) Attorney Name / Address: _____

Make / Model of Vehicle YOU were in: _____
Approx. speed of vehicles in accident YOUR VEHICLE: _____ OTHER VEHICLE(s): _____ _____ _____
Damage to YOUR VEHICLE:

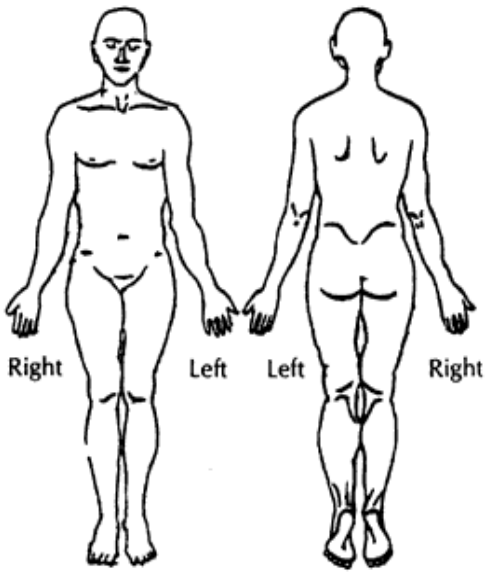
FRONT



REAR

Were you aware / surprised by the impact? YES NO
Was anyone else in YOUR vehicle? YES NO
Were there any witnesses to the accident? YES NO

Use the diagram to the right to show where your problem is located
Please use the line below to rate your level of discomfort today?
(*zero pain*) > 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 < (*worst pain*)
Is your problem a result of a work / auto related injury YES NO
How serious is this problem? _____
When does it bother you most? _____
Is there ANYTHING you cannot do as a result of this injury? _____
_____
_____
_____
_____
_____
Does anything else happen with this problem? _____
_____
_____
_____
_____
_____



Do you use tobacco products? YES NO If "yes" how often? _____
How often do you drink alcohol? YES NO If "yes" how often? _____
Do you drink TEA or COFFEE? YES NO If "yes" how often? _____
Do you drink caffeinated drinks or colas? YES NO If "yes" how often? _____
Do You take any Medications? YES NO If "yes" please list: _____
_____
Do you take any other drugs? YES NO If "yes" please list: _____
_____
Do you have ANY allergies? : YES NO If "yes" please list: _____
_____
Do you take any Supplements? YES NO If "yes" please list: _____
_____
How often do you drink water? _____ Do you buy bottled water? YES NO
Do you exercise? _____ Do you belong to a gym? YES NO

Please circle any of the problems listed below, which you are currently experiencing:

Fevers Vision Problems Painful Swallowing Heart Palpitations Vomiting Nausea
Headaches Rashes Double Vision Weakness Problems Urinating Dizzyness
Night Pain Numbness Uncontrolled Coughing Joint Swelling Muscle Pains
Incontinence Constipation Depression Shortness of Breath Black / Bloody Stools
Blurred Vision Wheezing Neck Pain Sweating under only 1 Arm Urinary Urgency Joint Pain
Low Back Pain Chest Pain Loss of voluntary movement Suicidal Thoughts Anxiety
Flashes in ONLY one (1) Eye Shoulder Pain Pain with Breathing Flashes in BOTH Eyes

My Chiropractic Center

Personal Injury Intake form (cont.)

Automobile Insurance Provider: _____

Plan / Group / Policy # _____ Agents Name: _____

If Insurance plan is through spouse / parent, please fill out the following:

Name of Policy Holder: _____ Their Date of Birth: _____

Address: _____ City: _____ State: _____

Policy Holder Phone: _____ Have you reported the accident to your insurance? YES NO

Adjuster's Name _____ Adjuster's Phone: _____

Accident Claim # _____

Health Insurance Provider: _____ Plan / Group # _____

If Insurance plan is through spouse –OR- If you have secondary insurance through your spouse, please fill out the following:

Name of Spouse: _____ Spouse 's Date of Birth: _____

Spouses Insurance Provider: _____ Plan / Group # _____

Spouses Employer: _____ Spouses Occupation: _____

Employer Address: _____ Spouses Work Phone: _____

Consent to treat a minor:

I, _____, Am the parent and / or legal guardian of _____ _____, born on _____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of _____ and I am not reasonably available by telephone to give consent. This authorization is effective from the date of _____ until terminated by the undersigned

Date: ____/____/____ Signature: _____

I certify that all information given in this documents, is correct to the best of my knowledge.

Date: ____/____/____ Signature: _____