Auto Injury Management Group
In Partnership with A Better Back Clinic
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Auto Collision / Personal Injury Intake Form

(Mark a ✓ on each that applies, ***N/A*** if does not applicable, ***Blank*** if don't know)

Today's Date: _____

Your Full Name: _____

Gender: ☐M ☐F **Marital Status:** ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Date of Birth: ____/____/____ **Age:** _____

Height: _____ **Weight:** _____ **Handed:** RT:____ LT:____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Social Security #: _____-_____-_____ **Driver's License #:** _____

Home Phone: (____) _____ **Cell Phone:** (____) _____

Email: _____ **Work Phone:** (____) _____

Occupation: _____

Employer: _____

Employer's Address: _____

Your Auto Insurance Information

Insured's Name (name the policy is under): _____ / _____
(Last) (First)

Relationship to patient (if policy is not under your name): _____

Insurance Company Name: _____

Auto Agents' Name: _____

Agent's Phone Number: _____

Do you have Med-Pay coverage? ☐Yes ☐No **Amount of coverage?** _____

Do you have under-insured / uninsured coverage? ☐Yes ☐No

Have you been issued a Claim # for this accident? ☐ Yes ☐ No

Claim #: _____

Were you at fault for this accident? ☐ Yes ☐ No

Other Party's Auto Insurance Information (If Applicable)

Other Party's Name: _____

Insurance Company Name of Other Person: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Claim #: _____

Have you retained an attorney? ☐ Yes ☐ No

Your Attorney's Name: _____

Your Attorney's Phone #: (____)_____ Fax: (____)_____

Your Attorney's Address: _____

City: _____ State: _____ Zip: _____

Did you take pictures? ☐ Yes ☐ No

(If so, of what) ☐ My car ☐ Other car(s) ☐ Accident scene ☐ Injured body part(s)

Collision Information

Date of Collision: _____/_____/_____ **Time of Collision:** _____ ☐ a.m. / ☐ p.m.

The weather conditions were: ☐ Sunny ☐ Raining ☐ Snowing ☐ Foggy

The road was: ☐ Dry ☐ Wet ☐ Icy **Light of day:** ☐ Dawn ☐ Day ☐ Dusk ☐ Night

I was the: ☐ Driver ☐ Passenger

If passenger, **where were you** sitting? ☐ Front Seat OR ☐ Back Seat ☐ Right Side ☐ Left Side

Your Vehicle: Year _____ Make _____ Model _____

Prior to impact your vehicle was:

☐ stopped at intersection light
☐ making a right turn
☐ stopped in traffic
☐ slowing down
☐ parking
☐ stopped at stop sign
☐ making a left turn
☐ proceeding along
☐ accelerating

Your Estimated Speed: _____ **Posted Speed Limit:** _____

Were you wearing your seatbelt? ☐ Yes ☐ No

Right hand: ☐ Steering wheel ☐ Center console ☐ In lap ☐ Door ledge ☐ Other: _____

Left hand: ☐ Steering wheel ☐ Center console ☐ In lap ☐ Door ledge ☐ Other: _____

Right foot: ☐ Gas ☐ Brake ☐ Floor board ☐ Fire wall ☐ Other: _____

Left foot: ☐ Gas ☐ Brake ☐ Floor board ☐ Fire wall ☐ Other: _____

Head position: ☐ Straight ahead ☐ turned left ☐ turned right ☐ bent down ☐ bent back

Torso position: ☐ Straight ahead ☐ turned left ☐ turned right ☐ bent down ☐ bent back

Head rest position: ☐ non- adjusted / lowest position ☐ middle position ☐ highest position

Seatback position: ☐ straight up-right ☐ slight recline ☐ full recline

Collision impending, were you: ☐ Fully Aware ☐ Aware only last second ☐ Unaware

Collision impending, were you: ☐ Fully Braced ☐ Braced at last second ☐ Not braced

Collision type: ☐ Rear ended ☐ Head-on ☐ Broad-sided ☐ Side swiped

Other Vehicle: Year _____ Make _____ Model _____

Prior to impact the other vehicle that struck you:

☐ ran the intersection light
☐ making a right turn
☐ weaving in and out of traffic
☐ proceeding along
☐ slowing down
☐ stopped behind / next / front of you

☐ ran the stop sign
☐ making a left turn
☐ accelerating
☐ slowing down

Their speed: _____ ☐ Estimated ☐ Told by Police Officer

Did your car spin / got spun? ☐ Yes ☐ No

Did your car get pushed from the point of impact? ☐ Yes ☐ No If yes, how far in feet? _____

After being hit did your car hit something else? ☐ Yes ☐ No If yes, what? _____

Did your airbag deploy? ☐ Yes ☐ No

Did you feel your body being jarred / jerked? ☐ Yes ☐ No

Did you feel your seat belt restrain you / engage? ☐ Yes ☐ No

Any bruising from the seat belt? ☐ Yes ☐ No If yes, where on your body? _____

Did any part of your body strike anything inside of your car: ☐ Yes ☐ No

If yes, what body part / what area of the car? _____ / _____

Were any inside parts of your vehicle displaced or broken: ☐ Yes ☐ No
If yes, list:_____

Were any personal items displaced or broken: ☐ Yes ☐ No
If yes, list:_____

Were you able to get out of the car? ☐ Yes ☐ No If yes, check one. ☐ On your own ☐ Assisted

Did you experience? Check all that apply.

☐ Shock ☐ Loss of balance ☐ Immediate Pain: Where? _____

☐ Dizziness ☐ Loss of Consciousness: How long?_____ ☐ Other _____

Unusual circumstances: (please note)
(i.e.: was anyone drunk, under the influence, emotionally unstable, speeding, out of control, etc.)

_____

Were there multiple vehicles involved? ☐ No ☐ Yes How many? #_____

In your own words describe collision:

_____

_____

_____

Draw a picture / Diagram of collision: (To be completed in office)

N

W **E**

S

Your vehicle damage: ☐ Mild ☐ Moderate ☐ Severe **Your car was** ☐ Drivable ☐ Towed

Estimated of damage to your vehicle: $_____ **Your car repaired yet?** ☐ Yes ☐ No

Other vehicle damage: ☐ Mild ☐ Moderate ☐ Severe ☐ Drivable ☐ Towed ☐ Hit / Run

Other vehicle's occupant(s) injured: ☐ Yes ☐ No ☐ Unsure ☐ Taken by Ambulance

Immediate Law Enforcement following the collision: (Mark a [✔] on each that applies)

- ☐ Police were called
- ☐ No police, we just exchanged information
- ☐ I was ticketed for the accident
- ☐ A Police report was done at the scene
- ☐ I have a copy of the police report
- ☐ Police showed to the scene
- ☐ Hit & Run, no information to exchange
- ☐ Other party was ticketed
- ☐ I filed a police report on my own

Police Department: _____ Officer's Name: _____

Witnesses

Was anyone else in the car with you: ☐ Yes ☐ No If yes, who? _____

Did any other person witness the accident? ☐ Yes ☐ No If yes, who? _____

Immediate medical help following the collision: Mark a [✔] on each that applies

☐ Ambulance / paramedics were called

☐ I was treated at the scene

☐ I was transported to hospital by ambulance

☐ Even though offered transport I opted not to. Why not? _____

☐ I went to the hospital on ☐ my own / ☐ via friend / ☐ via family. When? _____

☐ X-rays / MRI / cat scan done at hospital? What body area? _____

Was medication given at the hospital?: ☐ Yes ☐ No
If yes, what medications? _____

Was a prescription for medication to be taken at home provided? ☐ Yes ☐ No
If so, what medication was prescribed? _____
Filled the prescription given: ☐ Yes ☐ No

Was follow-up care recommended? ☐ Yes ☐ No
If yes, describe: _____

Name of Hospital: _____

For this Car Collision

Before coming to this office what other doctors have you seen? Check all that apply.

☐ Orthopedist ☐ Neurologist ☐ Psychiatrist ☐ Physiatrist ☐ Chiropractor

☐ Acupuncturist ☐ General Practitioner ☐ Physical Therapist ☐ Massage Therapist

Other: _____

If so, list: clinic, and/or practitioner's name, and approximate date(s) seen.

Clinic	Practitioner's Name	Approximate Date(s) Seen

Self-Care

What do you do or have done for yourself to relieve any the symptoms?

☐ Take non-prescription / over the counter medications

☐ Take prescription medications _____

☐ Recreational drugs _____

☐ Use ice

☐ Use heat

☐ Get extra rest / sleep

☐ Massage from family member / friend

☐ Do stretches

☐ Do exercises

☐ Massage self

Other: _____

Symptomatology: (Pain / Complaints) from this collision, even if only felt momentarily

Muscle – Skeletal

☐ Headaches / Migraines
☐ Neck Pain
☐ Top of Shoulder Pain
☐ Mid-Back Pain
☐ Along Shoulder Blades
☐ Low Back Pain
☐ Sacrum Pain
☐ Wrist / Carpal Tunnel
☐ Inside the Shoulder Pain
☐ Elbow / Arm Pain
☐ Hand / Fingers Pain
☐ Hip Pain
☐ Knee Pain
☐ Foot / Ankle / Toe
☐ Leg / Calf Pains
☐ Chest Pain
☐ Abdomen Pain
☐ Problem Sleeping
☐ Numbness in Arms / Hands
☐ Numbness in Legs / Feet
☐ Jaw Pain / clicking

Cognitive / Emotional / Sensory

☐ Ringing in Ear
☐ Difficulty Concentrating
☐ Sensitivity to Sound
☐ Depression
☐ Difficulty in Speech
☐ Typing / Writing Problems
☐ Vertigo / Dizziness
☐ Loss of memory
☐ Reading Problems
☐ Social withdrawn
☐ Nightmares
☐ Loss of Balance
☐ Vision changes
☐ Highly Emotional
☐ Loss of Taste
☐ Sensitivity Hot / Cold
☐ Fatigued
☐ Irritability
☐ Anxiety
☐ Loss of Smell
☐ Loss of Libido
☐ Blackouts
☐ Light sensitivity
☐ Apathy
☐ Loss of Hearing
☐ Suicidal thoughts

Systemic

☐ Asthma
☐ Nausea / Vomiting
☐ Digestive Problems Allergies
☐ Menstrual Irregularities
☐ Shortness of Breath
☐ High Blood Pressure
☐ Weight Loss / Gain
☐ Extreme Thirst

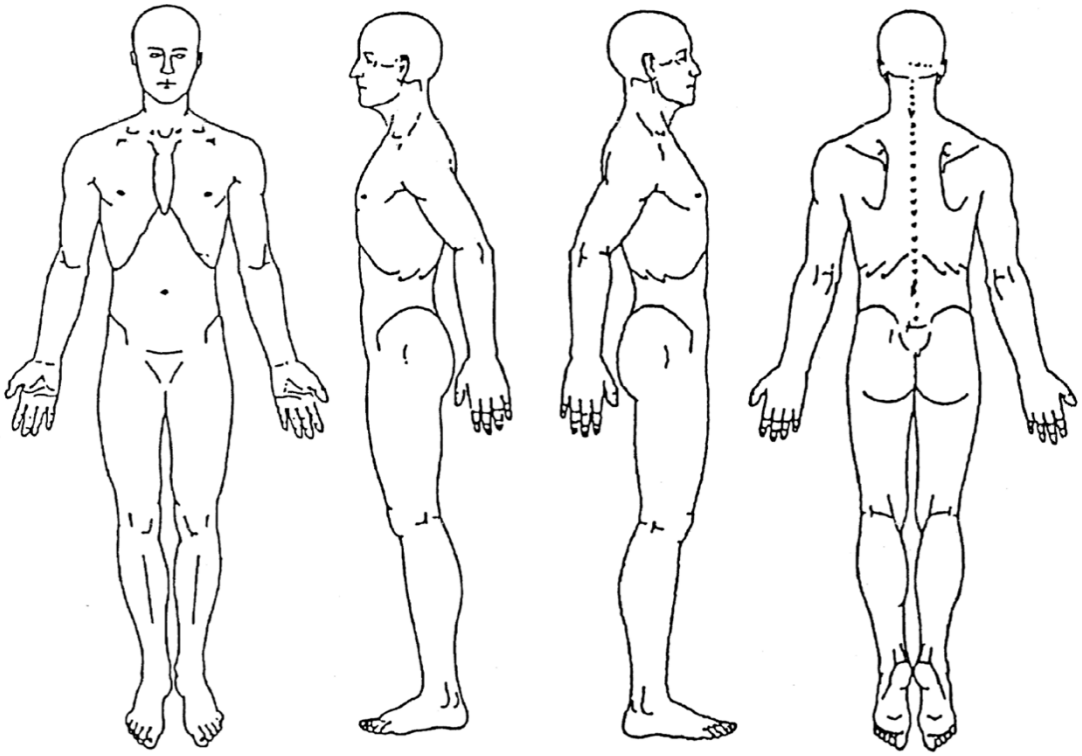
Miscellaneous

Other: _____

Your Overall Body Picture

Use symbols below to accurately mark the areas in which you feel: (To be completed in office)

Sharp: SSSS	Tingling: TTTT	Burning: BBBB	Cramping: CCCC
Numbness: NNNN	Dull: DDDD	Achy: AAAA	Pin / Needles: PPPP



Please prioritize each condition worst condition to least.

(1st) First body part / location: _____

(Were you ever treated professionally for this, prior to this car crash? ☐ Yes / ☐ No)

When did you start to feel this pain after the accident: (check) ☐immediately /☐within hours /☐next day /☐_____days?

Intensity: (at its best check) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

To: (at its worse check) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Current / average intensity: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Frequency: (check)

☐ Intermittent	☐ (0 to 25% of the day)
☐ Occasionally	☐ (26 to 50% of the day)
☐ Frequently	☐ (51 to 75% of the day)
☐ Constantly	☐ (76 to 100% of the day)

Timing: [✔] ☐Daily **OR** ☐Random (____days out of 7 days a of week)

Type of Discomfort (check): ☐Dull ☐Aching ☐Burning ☐Tingling ☐Numbness
☐Sharp ☐Shooting ☐Throbbing ☐ Spasm

Referring? (check) _____☐discomfort is localized
OR _____☐it extends If so, to where? (Fill in) _____

Things / times when aggravated / makes worse: (Fill in)_____

Things / times when relieved / make better: (Fill in) _____

(2nd) Second body part / location: _____

(Were you ever treated professionally for this, prior to this car crash? ☐Yes / ☐No)

When did you start to feel this pain after the accident? ☐immediately / ☐within hours / ☐next day / ☐_____days.

Intensity: (at its best check) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

TO (at its worse check) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Current / average intensity: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Frequency (check):
☐ Intermittent ☐ (0 to 25% of the day)
☐ Occasionally ☐ (26 to 50% of the day)
☐ Frequently ☐ (51 to 75% of the day)
☐ Constantly ☐ (76 to 100% of the day)

Timing: (check)☐Daily **OR** ☐Random (_____days out of 7 days a of week)

Type of discomfort (check): ☐Dull ☐Aching ☐Burning ☐Tingling ☐Numbness
☐Sharp ☐Shooting ☐Throbbing ☐ Spasm

Referring? (Check) _____☐discomfort is localized
OR _____☐it extends, if so, to where? (Fill in) _____

Things / Times when aggravated / makes worse: (Fill in) _____

Things / Times when relieved / make better: (Fill in) _____

(3rd) Third body part / location: _____

(Were you ever treated professionally for this, prior to this car crash? ☐Yes / ☐No)

When did you start to feel this pain after the accident: (check) ☐Immediately /☐within hours /☐next day /☐_____days?

Intensity: (at its best check) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

To: (at its worse check) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Current / average intensity: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Frequency: (check)
☐ Intermittent ☐ (0 to 25% of the day)
☐ Occasionally ☐ (26 to 50% of the day)
☐ Frequently ☐ (51 to 75% of the day)
☐ Constantly ☐ (76 to 100% of the day)

Timing: [✔] ☐ Daily **OR** ☐ Random (____ days out of 7 days a of week)

Type of Discomfort [✔] : ☐ Dull ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness
☐ Sharp ☐ Shooting ☐ Throbbing ☐ Spasm

Referring? (Check) _____ ☐ discomfort is localized
OR _____ ☐ it extends, if so, to where? (Fill In) _____

Things / times when aggravated / makes worse: (Fill In) _____

Things / times when relieved / make better: (Fill In) _____

(4th) Fourth body part / location: _____

(Were you ever treated professionally for this, prior to this car crash? ☐ Yes / ☐ No)

When did you start to feel this pain after the accident: (check) ☐ Immediately / ☐ within hours / ☐ next day / ☐ _____ days?

Intensity: (at its best check) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

To: (at its worse check) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Current / average intensity: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Frequency (check):
☐ Intermittent ☐ (0 to 25% of the day)
☐ Occasionally ☐ (26 to 50% of the day)
☐ Frequently ☐ (51 to 75% of the day)
☐ Constantly ☐ (76 to 100% of the day)

Timing: [✔] ☐ Daily **OR** ☐ Random (____ days out of 7 days a of week)

Type of Discomfort [✔] : ☐ Dull ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness
☐ Sharp ☐ Shooting ☐ Throbbing ☐ Spasm

Referring? (Check) _____ ☐ discomfort is localized
OR _____ ☐ it extends, if so, to where? (Fill In) _____

Things / Times when aggravated / makes worse: (Fill In) _____

Things / Times when relieved / make better: (Fill In) _____

(5th) Fifth body part / location: _____

(Were you ever treated professionally for this, prior to this car crash? ☐ Yes / ☐ No)

When did you start to feel this pain after the accident: (check) ☐ Immediately / ☐ within hours / ☐ next day / ☐ _____ days?

Intensity: (at its best check) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

To: (at its worse check) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Current / average intensity: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Frequency: (check)
☐ Intermittent ☐ (0 to 25% of the day)
☐ Occasionally ☐ (26 to 50% of the day)
☐ Frequently ☐ (51 to 75% of the day)
☐ Constantly ☐ (76 to 100% of the day)

Timing: [✔] ☐ Daily **OR** ☐Random (____ days out of 7 days a of week)

Type of Discomfort [✔]: ☐Dull ☐Aching ☐Burning ☐Tingling ☐Numbness
☐Sharp ☐Shooting ☐Throbbing ☐Spasm

Referring? (Check) _____ ☐discomfort is localized
OR _____ ☐it extends, if so, to where? (Fill In) _____

Things / Times when aggravated / makes worse: (Fill In) _____

Things / Times when relieved / make better: (Fill In) _____

(6th) Six body part / location: _____

(Were you ever treated professionally for this, prior to this car crash? ☐Yes / ☐ No)

When did you start to feel this pain after the accident: (check) ☐Immediately /☐within hours /☐next day /☐_____days?

Intensity: (at its best check) ☐ 0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

To: (at its worse check) ☐ 0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Current / average intensity: ☐ 0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Frequency: (check)
☐ Intermittent ☐ (0 to 25% of the day)
☐ Occasionally ☐ (26 to 50% of the day)
☐ Frequently ☐ (51 to 75% of the day)
☐ Constantly ☐ (76 to 100% of the day)

Timing: [✔]☐Daily **OR** ☐Random (____ days out of 7 days a of week)

Type of Discomfort [✔]: ☐Dull ☐Aching ☐Burning ☐Tingling ☐Numbness
☐Sharp ☐Shooting ☐Throbbing ☐Spasm

Referring? (Check) _____ ☐discomfort is localized
OR _____ ☐it extends, if so, to where? (Fill In) _____

Things / Times when aggravated / makes worse: (Fill In) _____

Things / Times when relieved / make better: (Fill In) _____

If additional body area(s), ask for an additional page.

Effects of your Injuries / Symptoms

[✔] on each that applies to your activities that your normally do that has been affected by injuries due to this collision:

☐ Have to hold onto something to sit or stand from a chair.

☐ Stay at home most of the time.

☐ Have to sit most of the day.

☐ Stays in bed most of the day.

☐ Change position frequently to try and get comfortable.

☐ Have difficulty turning over in bed.

☐ Have to lie down and rest frequently.

☐ Have to get other people to do things for me.

☐ Driving the car	☐ Bathing self	☐ Going to Restroom	☐ Climbing Stairs
☐ Dressing Self	☐ Sexual relationships	☐ Brushing teeth	☐ Combing Hair
☐ Shaving	☐ Washing dishes	☐ Dusting	☐ Going to the movies
☐ Doing Laundry	☐ Ironing	☐ Cooking	☐ Vacuuming
☐ Dining Out	☐ Shopping	☐ Kneeling	☐ Social events
☐ Going to Church	☐ Weightlifting	☐ Reading	☐ Watching TV
☐ Child care	☐ Using phone	☐ Computer work	☐ Lawn mowing
☐ Gardening	☐ Washing Car	☐ Landscaping	☐ Taking out Trash
☐ Outdoor Maintenance	☐ Aerobic exercising	☐ Backpacking	☐ Basketball
☐ Bowling	☐ Boxing	☐ Bicycling	☐ Baseball
☐ Fishing	☐ Sewing	☐ Yoga	☐ Dancing
☐ Camping	☐ Card Playing	☐ Handball	☐ Golf
☐ Football	☐ Martial Arts	☐ Hunting	☐ Hockey
☐ Health Club	☐ Gymnastics	☐ Ice skating	☐ Horseback riding
☐ Sailing	☐ Rafting	☐ Racquetball	☐ Photography
☐ Jogging	☐ Swimming	☐ Snow Skiing	☐ Water sports

Other: _____

How do the following positions or motions affect your pain?

Sitting: ☐ No Change ☐ Relieves ☐ Increased
If increased, duration limited to #? _____ ☐ Hours / ☐ Minutes

Walking: ☐ No Change ☐ Relieves ☐ Increased
If increased, duration limited to #? _____ ☐ Hours / ☐ Minutes

Standing: ☐ No Change ☐ Relieves ☐ Increased
If increased, duration limited to #? _____ ☐ Hours / ☐ Minutes

Lying Down: ☐ No Change ☐ Relieves ☐ Increased
If increased, duration limited to #? _____ ☐ Hours / ☐ Minutes

Looking Up: ☐ No Change ☐ Relieves ☐ Increased
If increased, duration limited to #? _____ ☐ Hours / ☐ Minutes

Lifting: ☐ No Change ☐ Relieves ☐ Increased
If increased, approximately how much? _____ Weight / Amount _____

Bending: ☐ No Change ☐ Relieves ☐ Increased
If increased, how many? _____ Repetitions / # of _____

Sleeping: ☐ No Change ☐ Relieves ☐ Increased
If increased, interrupted: Current # _____ of hours uninterrupted
Prior # _____ of hours uninterrupted

Employment History / Change

Were you employed at the time of the collision? ☐ Yes ☐ No

Did you lose your job due to this collision? ☐ Yes ☐ No

Employer: _____

Company Name: _____

Supervisor / Boss Name: _____

Your Job Title: _____

Your Job Duties: _____

_____

Loss time from work due to this collision?: ☐ Yes ☐ No

If yes:

Day	Date	Amount of Time

Has /Have you and or your Boss modified any of your work responsibilities due to the effects of this collision? ☐ Yes ☐ No

If so, explain:

_____

_____

_____

Have you've been in any prior motor vehicle accident?

☐ No ☐ Yes When? _____

Do you receive professional treatment for any injuries? ☐ No ☐ Yes

If yes, when was the last treatment given / visit? _____

_____

Any other accidents that you have injuries from & been treated for? ☐ Work / ☐ Slip / ☐ Fall

☐ No ☐ Yes When? _____

If yes, when was the last treatment given / visit? _____

Prior Medical History You Have Been Treated For (Before / Outside This Car Crash)

Other doctors seen for health conditions (Before or not from this car crash) in last 7 years:

☐ Physical Therapist ☐ Neurologist ☐ Psychiatrist ☐ Physiatrist ☐ General Practitioner

☐ Acupuncturist ☐ Chiropractor ☐ Orthopedist ☐ Massage Therapist

Other: _____

If so give:

Clinic and /or Practitioner's Name	Approximate Date(s) Seen

Personal Medical History & Review of Systems

Please indicate with a "X" any medical problems that you currently have or have had in the past.

Lungs / Pulmonary / Breathing Disorders

☐ asthma ☐ pulmonary embolism ☐ respiratory arrest

☐ COPD ☐ pneumonia ☐ sleep apnea

☐ emphysema ☐ tuberculosis ☐ other: _____

☐ no known problems

Cardiac / Heart / Peripheral Vascular Disease

☐ chest pain / angina ☐ high blood pressure ☐ irregular heartbeat, arrhythmia

☐ heart attack ☐ heart murmur, valve disorder ☐ peripheral vascular disease

☐ congestive heart failure ☐ mitral valve prolapse ☐ deep vein thrombosis

☐ other: _____ ☐ bleeding problems ☐ no known problems

Neurologic Disorders

☐ stroke or TIA ☐ Parkinson's ☐ cerebral palsy

☐ peripheral neuropathy ☐ MS ☐ polio

☐ other: _____ ☐ no known problems

Bone & Joint Disorders

☐ osteoarthritis ☐ gout ☐ osteomyelitis

☐ rheumatoid arthritis ☐ lupus ☐ ankylosing spondylitis

☐ other: _____ ☐ no known problems

Gastrointestinal Disorders

☐ peptic ulcer or stomach ulcer ☐ diverticulitis ☐ hepatitis - Type _____

☐ acid reflux, GERD ☐ irritable bowel ☐ liver disease

☐ GI bleed ☐ inflammatory bowel disease

☐ other: _____ ☐ no known problems

Genitourinary Disorders

☐ urinary tract infection ☐ kidney problems ☐ dialysis, kidney failure

☐ bladder problems ☐ kidney stones ☐ other: _____

☐ no known problems

Metabolic & Other Disorders

☐ Diabetes x _____ years ☐ skin disorder _____ ☐ depression

☐ thyroid problems ☐ psoriasis ☐ anxiety

☐ sickle cell disease ☐ any skin ulcer ☐ alcohol or drug dependency

☐ high cholesterol or lipids ☐ tooth abscess, gingivitis ☐ other: _____

☐ no known problems

Cancer (Any Type)

☐ Yes ☐ No If yes, please specify type: _____

☐ no known problems

Allergies: (please list all medications, food environmental issues that cause allergic reaction)

_____ _____ _____

_____ _____ _____

Medications: (please list all medications, social drugs and supplements that you currently take)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____

_____

_____

Other medical problems NOT included above (explain): _____

_____

Family Medical History: (Mom, Dad, Brother, Sisters, Aunts, Uncles, Grandparents)

Please indicate with an "✔" any significant family medical history or problems.

☐ asthma	☐ tuberculosis	☐ sleep apnea
☐ COPD or Emphysema	☐ other lung : _____	
☐ heart attack	☐ myocardial infarction	☐ congestive heart failure
☐ Peripheral neuropathy	☐ bleeding problems	☐ irregular heartbeat, arrhythmia
☐ MS or Parkinson's	☐ other neuro : _____	
☐ osteoarthritis	☐ Lupus	☐ gout
☐ rheumatoid arthritis	☐ Other bone & joint: _____	
☐ acid reflux, GERD	☐ inflammatory bowel disease	☐ hepatitis - type _____
☐ liver disease	☐ other GI : _____	
☐ kidney problems	☐ dialysis, kidney failure	☐ diabetes
☐ psoriasis	☐ high cholesterol or lipids	☐ thyroid problems
☐ sickle cell disease	☐ any skin ulcer	☐ Malignant hyperthermia

Family Cancer: any type - please specify

_____

Other Family medical problems NOT included above (explain)

_____

Social Habits:

Alcohol: ☐ Does not drink alcohol OR ☐ # _____ Drinks per week

Smokes: ☐ Does not Smoke OR ☐ # _____ ☐ packs / ☐ day and packs / ☐ week (check)

Recreational Drugs: ☐ Does not Take OR ☐ Consumes _____

Exercise Habits: Reports # _____ times / week

Type of Activities: _____

Diet and Nutrition: Reports ☐ Unrestricted ☐ Restricted-Avoids: _____

Hobbies: Type of Activities: _____

Have any of the above exercises or hobbies been affected / changed since the current motor vehicle accident?
☐ Yes ☐ No

If so, how?

_____

_____

I ATTEST THAT I have reviewed pages 1 through 16 of this Auto Collision / Personal Injury Intake form and the information I have provided, is to the best of my Abilities, Truthful / Factual / Accurate.

Printed Name: _____ **If for/minor's name:** _____

_____ _____

Signature Field **Date**