Total Family Health
Maximize Chiropractic

Maximize Chiropractic –Personal Injury Intake Form

Whom may we thank for referring you to this office → ___________________________________

Today's Date: ___________________ HR#: ______________________

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: _____-_____-_____ Age: _________ ☐ Male ☐ Female

Address: ____ City: ________________________________ State: _____ Zip: ____________

E-mail Address: _____________________________________ Home Phone: _______________________ Mobile Phone:_______________

Marital Status: ☐ Single ☐ Married ☐ Other:__________________ ☐ No Work Phone: ______________________________

Social Security #: ___________________________________ Driver's License #: ___ ____

Employer: ____ Occupation: ____

Spouse's Name _____________________________________ Spouse's Employer ____

Name & Number of Emergency Contact: ______________________ ___________________Relationship: ____________________________

Do you have an attorney representing you for your accident? ☐ Yes ☐ No If yes, attorney name: _______________________________

HISTORY of COMPLAINT

Please check the symptoms you have developed since the accident

☐ Headache	☐ Numbness in feet **R L Both**	☐ Loss of Memory	☐ Pain Behind Eyes
☐ Neck Pain/Stiffness	☐ Arm Weakness **R L Both**	☐ Dizziness	☐ Jaw Popping
☐ Mid Back Pain	☐ Leg Weakness **R L Both**	☐ Sleeping Problems	☐ Numbness in Fingers
☐ Facial Pain	☐ Low Back Pain	☐ Eyes Light Sensitive	☐ Fainting
☐ Irritability	☐ Arm Pain **R L Both**	☐ Fatigue	☐ Shortness of Breath
☐ Loss of Balance	☐ Leg Pain **R L Both**	☐ Depression	☐ Ringing/Buzzing in Ears
☐ Cold Feet	☐ Muscle Sapsm/Cramping	☐ Cold Hands	☐ Chest Pain
☐ Diarrhea	☐ Shoulder Pain **R L Both**	☐ Constipation	☐ ___________________

ABOUT the ACCIDENT

1. What was the date of the accident? _____________ Time of Day: ______________ AM PM
2. Where were you in the vehicle: ☐ Driver Seat ☐ Front Passenger ☐Rear Passenger L R ☐ Other_______________
3. Cars involved in accident: Year, Type, and estimated speed

Your Car	Year________	Make ________________	Model ____________________	Speed _________
Other Car	Year________	Make ________________	Model ____________________	Speed _________
Third Car	Year________	Make ________________	Model ____________________	Speed _________

4. Type of accident: ☐ Head-on Collision ☐ Broad-Side Collision ☐ Roll-over ☐ Pedestrian/Bicycle ☐ _______________
5. Please describe the accident in your own words: ____

____

____

____

6. Head/Body position at time of impact: ☐ Head turned left ☐ Head turned right ☐ Head faced forward
☐ Body rotated left ☐ Body rotated right ☐ Body faced forward

7. Were you wearing your seatbelt? ☐ Yes ☐ No

8. Did you brace yourself for the impact: ☐ Yes ☐ No

9. Upon impact, do you recall striking any objects inside of the car? ☐ Yes ☐ No

   If yes, what objects did you strike? ____

10. Since the accident, how are conditions becoming ☐ Better ☐ Worse ☐ About the same

11. Do your symptoms ☐ Come and Go, or are they ☐ Constant

12. Describe the symptoms you felt:

    Immediately after the accident :____

    Later that day:____

    The next day:____

13. Were you transported to the hospital by ambulance? ☐ Yes ☐ No

14. Did you go to the hospital on your own? ☐ Yes ☐ No

15. What helps relieve your symptoms?____

16. What aggravates your symptoms? ____

17. What were the road conditions at the time of the accident? ☐ Dry ☐ Wet ☐ Icy ☐ Snow ☐ __________________

18. What was the visibility at the time of the accident? ☐ Good ☐ Fair ☐ Poor

19. Where was your car struck? ____

20. Did you lose consciousness after the accident? ☐ Yes ☐ No

PAST HISTORY

Do you have any prior history of any of the symptoms you checked above? ☐ Yes ☐ No If yes, explain:________________________

____

Have you ever been involved in any prior automobile accidents or ever had any serious falls/injuries? ☐ Yes ☐ No If yes, explain:

____

What medications are your currently taking? ____

____

HEALTH HISTORY

If you have ever been diagnosed with any of the following conditions, please indicate with a P for in the Past, or C for Currently.

___ Broken Bone ___ Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture
___ Disability ___ Cancer ___ Heart Attack ___Osteo Arthritis ___ Diabetes
___ Cerebral Vascular ___ Other serious conditions:____

SOCIAL HISTORY

1. Smoking: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

I hereby authorize payment to be made directly to Nicholl Chiropractic Inc., for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Nicholl Chiropractic Inc. for any and all services I receive at this office.

Cancellation Policy – 24 hour notice for all scheduled appointments - $65 fee

________________________________ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

YOUR AUTO INSURANCE INFORMATION

Insurance Company Name: ____

Claim Number:____

Adjuster Name: ____

Adjuster Phone: ____

Adjuster Fax: ____

Address to send claims: ____

You have Medical Payment coverage? YES NO If yes, amount of coverage:

THE OTHER PARTY'S INFORMATION

Driver Name:____

Driver's Insurance Company: ____

Claim Number:____

Adjuster Name:____

Adjuster Phone:____

PLEASE PROVIDE US WITH THE FOLLOWING ITEMS ON YOUR FIRST APPOINTMENT

Driver's License

Health Insurance Card

Auto Insurance Card

Auto Insurance Declaration Page

MP SP ATTY