

No Fault Intake Form

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| | | |
|-------------------|--------------|-------------|
| Practitioner Name | Today's Date | Referred by |
|-------------------|--------------|-------------|

PERSONAL INFORMATION

| | | | | | |
|------------------------|----------------|---------------|------------------------|---------------|---------------|
| Patient Last Name | First Name | MI | Gender M F | Age | Date of Birth |
| Home Phone # () | | | Work Phone # () | | |
| Patient Address | City | State | | Zip Code | |
| In case of emergency | Marital Status | Children # of | Email Address | | |
| Occupation | Employer | | | Yrs. Employed | |
| Employer Address | City | State and Zip | | Phone # | |

PRIMARY CARE PHYSICIAN INFORMATION

| | | | | | |
|-----------|------------|--|----------|---------|--|
| Last Name | First Name | Have you seen your primary Doctor for this complaint? Yes No Date | | | |
| Address | City | State | Zip Code | Phone # | |

AUTO ACCIDENT INFORMATION

| | | | | |
|-----------------------|-----------------------------------|-------|----------|---------|
| Date of Accident: | Time of Day: | | | |
| Name of Insurance: | Agents Name: | | | |
| Ins. Address | City | State | Zip Code | Phone # |
| Ins. Case #(if known) | Were there any previous injuries? | | | |

HISTORY OF CURRENT COMPLAINT:

When does your complaint feel worse? AM PM Please explain _____

Does your pain interrupt your sleep? No Yes please explain: _____

What activity is affected most due to this complaint? _____

PREVIOUS CONDITIONS AND TREATMENTS:

In your own words, please briefly list any previous medical conditions and treatment: _____

List all medications and supplements: _____

Do you have any Allergies NO Yes please explain _____

List all dates of hospital visits and or types of Surgeries: _____

Are there any of these conditions in your family history? ___ Autoimmune disorders ___ Cancer ___ Diabetes
___ Heart Disease ___ Neurological ___ Arthritis ___ Kidney disease ___ Seizure Disorder

ACCIDENT DETAILS:

Where you: Driver Front Passenger Back Passenger Pedestrian (not in car)

Number of people in vehicle: _____ Other vehicle? _____

What direction were you headed? North East South West

On (name of Street) _____

What direction was other vehicle headed? North East South West

On (name of Street) _____

What type of vehicle were you driving? _____ -

What was your vehicle doing just prior to the accident?

Stopped at light Merging traffic Increasing speed slowing to stop Changing lanes

Traveling at an approximate speed of: _____ mph

Who hit who?

- You were struck by other car You struck other car You struck stationary object

What was your vehicles point of impact?

- Front Rear Right Side Left Side
 Right Front Left Front Right Rear Left Rear

What was the other vehicle doing just prior to the accident?

- Stopped at a stop light Merging into traffic Increasing speed
 At a complete stop Slowing down to a stop Changing lanes

Traveling at an approximate speed of: _____ mph

What was the other vehicles point of impact?

- Front Rear Right Side Left Side
 Right Front Left Front Right Rear Left Rear

Were you wearing seat restraints?

- Full lap and shoulder Lap only Shoulder only Not wearing seatbelt

What position were your vehicles head rests in?

- Lowest Position Middle Position Highest Position No Head rest in Vehicle

Did your vehicles airbags deploy? Yes No

Were you prepared for the impact?

- Came as a complete surprise Aware, braced for collision Aware, not braced for collision

What position was your head and neck in prior to the impact?

- Straight forward Tilted forward Rotated to the left
 Rotated to the right Turned Around Toward rear view mirror

What happened to your body at the moment of impact?

- Body was tensed for impact Body Whipped forward/backward
 Body torqued and twisted Body was thrown over seat
 Body was thrown from vehicle Body was pinned in vehicle
 Body was thrown from side to side Body was cut and bruised

What was your mental/emotional state immediately following?

- Unconscious Disoriented Shaken up Disoriented & Shaken up

Did you receive medical attention at the scene of the accident? Yes No

Where did you go immediately following the accident?

- Hospital Personal Doctor This office Home Resumed daily activities

Please describe how you felt:

Immediately after the injury: _____

Later that Day: _____

The Next Day: _____

What are your present complaints and symptoms? _____

Since this injury occurred are your symptoms: Improving Getting Worse Same

Have you lost time at work as a result of the injury? Yes No

If yes please complete this question: Last Day Worked _____

Are you being compensated for lost time from work? Yes No

If yes, type of compensation: _____

Do you notice any activity restrictions as a result of this injury? Yes No

If yes please describe in detail: _____

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date: ____/____/____

If patient required assistance to complete, sign name and state relationship(i.e., parent, translator) below:

Name _____ Relationship _____ Today's date: ____/____/____