Milton Chiropractic
& Rehabilitation, Inc.

Personal Injury Intake Form

File Number (Office Use) _____

Patient Information:

Today's Date _____ Home Phone _____
Name _____ Cell Phone _____
I prefer to be called _____ Preferred Contact **Home** **Cell**
Address _____ Email _____
_____ Social Security # _____
_____ Date of Birth _____
Sex **Male** **Female** Height ____' ____" Weight _____ lbs
Occupation _____ Marital Status _____
Employer _____ No of Children _____
Address _____ Phone: _____
If minor, name of parent or guardian _____
Who should we contact in case of an emergency? _____
Relation _____ Phone _____
Address _____
Attorney _____ Phone _____
Primary Care Physician _____ Phone _____
» Is He/She within Harvard Vanguard Medical Group **YES** **NO**
How did you hear about our office? _____
Have you ever been to a chiropractor? **YES** **NO** Who? _____

Auto Insurance Information:

Insurance Company _____ Policy number _____
Address _____ Phone _____
Adjustor Name _____ Claim # _____

Accident Information:

Date _____ Time _____ AM PM Was it reported to the police? **YES** **NO**
Was a traffic violation issued? **YES** **NO** To whom? _____
Location of accident (Street, Town) _____ # of other passengers _____
Were there other witnesses? **YES** **NO**
Please explain in detail how the accident occurred _____
_____
_____
_____
Were you the **DRIVER** **FRONT SEAT PASSENGER** **BACK SEAT PASSENGER**?
Were you wearing a seat belt? **SHOULDER HARNESS** **LAP HARNESS**
Approx. speed of YOUR vehicle ____MPH Approx. speed of OTHER vehicle ____MPH
Did the impact to your vehicle come from the: **FRONT** **REAR** **RIGHT** **LEFT** **OTHER**
During impact, were you facing: **RIGHT** **LEFT** **FORWARD**
Were you **AWARE** or **SURPRISED** by the impact?

Patient Signature: _____ **Date:** _____

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Was the vehicle equipped with air bags? **YES** **NO** Did they inflate? **YES** **NO**
In relation to the base of your skull, where was the headrest? **ABOVE** **BELOW** **AT BASE**
What did your vehicle impact? **ANOTHER VEHICLE** **OTHER** _____
If another vehicle, what was the make/model? _____ Direction _____Speed _____MPH
Did any part of your body strike anything in the vehicle? **YES** **NO** Describe _____
Did the accident render you unconscious? **YES** **NO** If yes, for how long? _____

Post-Accident Information:

Please describe your **PAIN(S)** and its **LOCATION** _____
_____
_____
When did the(se) symptoms begin **IMMEDIATELY** **LATER,SAME DAY** **DIFFERENT DATE**
___/___/___
Has your condition **IMPROVED** **WORSENED** or **STAYED SAME** since the accident?
Have you seen any other doctor(s) since the accident? **YES** **NO** Name _____
When did you go? **IMMEDIATELY** **NEXT DAY** **2 DAYS PLUS**
How did you get there? **AMBULANCE** **PRIVATE TRANSPORTATION**
Name of hospital and/or attending doctor: _____
Was he/she a: **D.C.** **M.D.** **D.O.** **D.D.S.**
Please describe any treatment you received _____
Were X-Rays done? **YES** **NO** MRI? **YES** **NO** CT Scan? **YES** **NO**
Was medication prescribed? **YES** **NO** If yes, what? _____

Job-Related Information

Have you missed any work since the accident? **YES** **NO** Date(s) _____
Are your work activities restricted as a result of your injury? **YES** **NO**
Is your condition affecting your **WORK** **SLEEP** or **DAILY ROUTINE**? Please explain _____
_____
How many hours are in your normal workday? _____
Please indicate your daily job duties and any activities that you are occasionally asked to perform:

STANDING	**OPERATING EQUIPMENT**	**DRIVING**	**SITTING**
TWISTING	**WORK W/ARMS ABOVE HEAD**	**WALKING**	**CRAWLING**
TYPING	**LIFTING**	**BENDING**	**STOOPING**

While in recovery, are there any light duty tasks you could request? **YES** **NO** Please explain
_____
_____

Patient Signature: _____**DOB:**_____ **Date:** _____

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Health History

Please list all medications you are currently taking for this or any other health condition.

_____

_____

_____

Please list any medical conditions that you currently have or have ever had. _____

_____

_____

Please list anything that you may be allergic to. _____

_____

Please list previous surgeries/treatments with dates. _____

_____

Please list any past serious accidents with dates. _____

_____

Please list any family medical health conditions? _____

_____

Do you: Take supplements or vitamins? **YES** **NO** Exercise? **YES** **NO**

Are you on a special diet? **YES** **NO** Since: _____/_____/_____

Do you smoke? **YES** **NO** How much? _____ How long? _____
Former Smoker, but have quit Years Since last Smoked _____

Are you wearing: **HEEL LIFTS** **SOLE LIFTS** **INNER SOLES** **ARCH SUPPORTS** ?

For Women: Are you taking birth control? **YES** **NO**
Are you pregnant? **YES** **NO** Due Date ___/___/___

Tests: (related to this problem)

Test	Have you had this test?	Date performed	Did you bring copy today?
X-ray	Y or N		Y or N
MRI	Y or N		Y or N
CT Scan	Y or N		Y or N
Bone Scan	Y or N		Y or N
EMG	Y or N		Y or N
Other:	Y or N		Y or N

Patient Signature: _____DOB:_____ Date: _____

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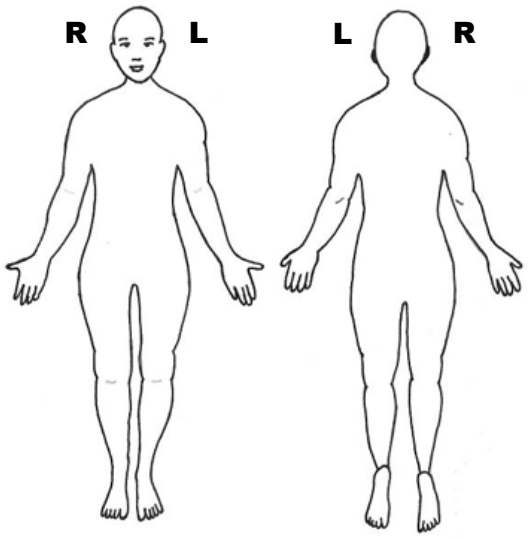
Please mark these drawings to show the location of your **CURRENT** symptoms and the type of symptoms you are experiencing.

Sharp Pain: ////// **Achy Pain:** ^^^^^ **Burning Pain:** XXXXX **Numbness:** 0000



Circle the number corresponding with the intensity of your symptoms.
"**0**" = **No Pain** where as a **"10" = most severe pain imaginable.**

Location:_____1 2 3 4 5 6 7 8 9 10

Location:_____1 2 3 4 5 6 7 8 9 10

Location:_____1 2 3 4 5 6 7 8 9 10

Location:_____1 2 3 4 5 6 7 8 9 10

Please Answer "YES" or "NO" As It Pertains to Your Health

CONSTITUTIONAL
Weight Loss Y N
Fatigue Y N
Fever Y N

EYES
Glasses/Contacts Y N
Eye Pain Y N
Double Vision Y N
Cataracts Y N

CARDIOVASCULAR
Murmur Y N
Chest Pain Y N
Palpitations Y N
Fainting/Spells Y N
Short of Breath Y N
Difficulty Lying Flat Y N
Swelling in Ankles Y N

ENDOCRINE
Loss of Hair Y N
Heat Intolerance Y N
Cold Intolerance Y N

PSYCHIATRIC
Anxiety Y N
Depression Y N
Mood Swings Y N
Difficulty Sleeping Y N

RESPIRATORY
Cough Y N
Coughing Blood Y N
Wheezing Y N
Chills Y N

GASTROINTEST
Heartburn/Reflux Y N
Nausea/Vomiting Y N
Constipation Y N
Change Bowel Mvts Y N
Diarrhea Y N
Jaundice Y N
Abdominal Pain Y N
Black/Bloody Bowel Mvts Y N

GENITOURINARY
Burning/Frequency Y N
Nighttime Y N
Blood in Urine Y N
Erectile Dysfunction Y N
Bladder Leakage Y N
Abnormal Leakage Y N

ALLERGIC
Hives/Eczema Y N
Hay Fever Y N

HEMATOLOGY/LYMPH
Bruise Easily Y N
Gums Bleed Easily Y N
Enlarged Glands Y N

MUSCLE/BONE
Joint Pain/Swelling Y N
Stiffness Y N
Muscle Pain Y N
Bone Pain Y N

SKIN
Rashes/Sores Y N
Lesions Y N
Itching/Burning Y N

NEUROLOGICAL
Loss of Strength Y N
Numbness Y N
Headaches Y N
Tremors Y N
Memory Loss Y N

FEMALES ONLY
Age Onset of Periods_____
Periods Regular? Yes_____No_____
Age Onset of Menopause_____
Number of Pregnancies_____

Patient Signature:_____**DOB**_____**DATE**_____

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& Rehabilitation, Inc.

Acknowledgement of Office Policies

The following are Milton Chiropractic & Rehabilitation, Inc. policies. Please read carefully AND INITIAL beside each section before signing the bottom, and be sure to ask any questions you might have before signing the document.

Appointment Scheduling. We at Milton Chiropractic & Rehabilitation, Inc. are glad to accept insurance assignment on your behalf in handling payment for the care you receive. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the recommended care program. This means that if you miss several appointments without notifying our office (emergencies considered), you may be dismissed from care and your file may be closed._____

Consent for Treatment. I, the undersigned, give Milton Chiropractic & Rehabilitation, Inc. my permission to evaluate (including x-rays if needed) and treat my injury as deemed reasonable and necessary. I further understand that with any diagnostic or therapeutic procedure there is always risk of injury or worsening of my condition on rare occasions (ie. increased pain, muscle spasm, rib injury, etc). Risk of such injury or complications from chiropractic treatments are substantially lower than that associated with many medical procedures or medications given for the same symptoms. I further understand that **no guarantee or promise** has been made to me concerning the results of treatment._____

Assignment of Payment. I hereby **authorize** my insurance company and/or my attorney to pay direct to Milton Chiropractic & Rehabilitation, Inc. any monies due on my account for professional services rendered._____

Acknowledgement and Understanding. It is further understood that I, the undersigned, **agree to pay the full amount** of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office. _____

Private Health Insurance. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments). _____

Authorization to Release Information. I understand that Milton Chiropractic & Rehabilitation, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payments. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Milton Chiropractic & Rehabilitation, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. _____

Patient Requests for Records. I **authorize** the release of all medical, hospital, or surgical records pertinent to my care, including but not limited to, exams, special tests, x-rays, or lab results to this office. _____

Ownership. I understand that Milton Chiropractic, Bay State Physical Therapy, Optimal Weight Loss and Massage Works! are all owned and operated by the same entity. I understand I have the option to seek any/all of the same services these clinics provide elsewhere. _____

I certify that I have read and understand all appointment and office policies listed above.

Name(print) _____Signature _____DOB_____Date _____