INJURY TREATMENT CENTERS

New Patient Information

Name: _____ Date of Injury/Illness: _____/_____/_____

Date of Birth: _____/_____/_____ Sex: M / F Social Security # _____

Address: _____ Apt #_____

City: _____ State: _____ Zip: _____

Cell Phone: (_____)_____-_____ Other Phone: (_____)_____-_____

Work Phone: (_____)_____-_____ Email: _____

Emergency Contact: _____ Relationship: _____

Phone: (_____)_____-_____ Email: _____

Insured or Responsible Party (if different from patient)

Name: _____ Date of Birth: ____/____/_____ Social Security #_____

Address: _____ Apt #_____

City: _____ State: _____ Zip: _____

Phone: (_____)_____-_____ Email: _____

Injury and Insurance Information

Date of Injury: _____/_____/_____

How were you injured? ☐ Auto Accident ☐ Work Accident ☐ Other: _____

Personal Auto or Workers Comp Insurance: _____ Claim # _____

Insurance Contact Person: _____ Phone: (_____)_____-_____

At-fault Auto Insurance Company if available: _____ Claim # _____

Insurance Contact Person: _____ Phone: (_____)_____-_____

Health Insurance Company: _____ Policy Holder: _____

Policy # _____ Group # _____ Phone: (_____)_____-_____

General Information

How did you hear about our clinic? _____

Referring Physician: _____ Phone: (_____)_____-_____

Do you have an attorney? Y / N

Attorney/Law Firm: _____ Phone: (_____)_____-_____

Patient/Responsible Party Signature: _____ Date:_____/_____/_____

Life can't wait.

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Patient Name: _____ **Date of Injury:** _____/_____/_____

If you were hurt in an auto accident, please fill out the following information

What was your position? ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other: _____

Where was the impact? ☐ Rear ☐ Front ☐ Driver's side ☐ Passenger Side ☐ Other: _____

Were you wearing a seatbelt? Y / N Did the airbags deploy? Y / N

At the time of the impact were you looking: ☐ Up ☐ Down ☐ Right ☐ Left ☐ Straight Ahead

Was your foot on the brake? Y / N If yes: ☐ Right Foot ☐ Left Foot ☐ Both Feet

Were your hands on the steering wheel? Y / N If yes: ☐ Right Hand ☐ Left Hand ☐ Both Hands

Did you hit any other part of your body? Y / N If yes, explain: _____

Did you lose consciousness? Y / N If yes, explain: _____

Did you go to the hospital/urgent care? Y / N If yes, which location: _____

How soon did you go to the after the accident? ☐ Immediately ☐ Next Day ☐ 2 or more days later

What injuries did the hospital/urgent care diagnose? _____

Have you had X-rays or other imaging? Y / N If yes, explain: _____

Medical History

Are you under a Doctor's care for any condition? Y / N If yes, who is your Doctor?_____

Please list any medications you are currently taking: _____

_____

List any allergies to medications you may have: _____

_____

Previous Hospitalizations:

Year: _____ Hospital: _____ Reason: _____

Year: _____ Hospital: _____ Reason: _____

Other Serious Injuries/Illness/Surgeries:

Year: _____ Injury/Illness/Surgery: _____

Year: _____ Injury/Illness/Surgery: _____

Social and Family History

Occupation: _____ Does your job require heavy lifting? Y / N

Do you use any of the following? ☐ Alcohol ☐ Tobacco ☐ Street Drugs ☐ Other: _____

Do any of your family members have serious medical conditions we should be aware of? Y / N

If yes, explain: _____

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Accident Information

Please describe the accident/injury in your own words: _____

_____

_____

_____

Rate the severity of your current pain from **1** (least amount of pain) to **10** (severe amount of pain): _____

How would you rate your pain at the time of the accident/injury from **1** to **10**? _____

What makes the pain better? _____

What makes the pain worse? _____

Symptoms

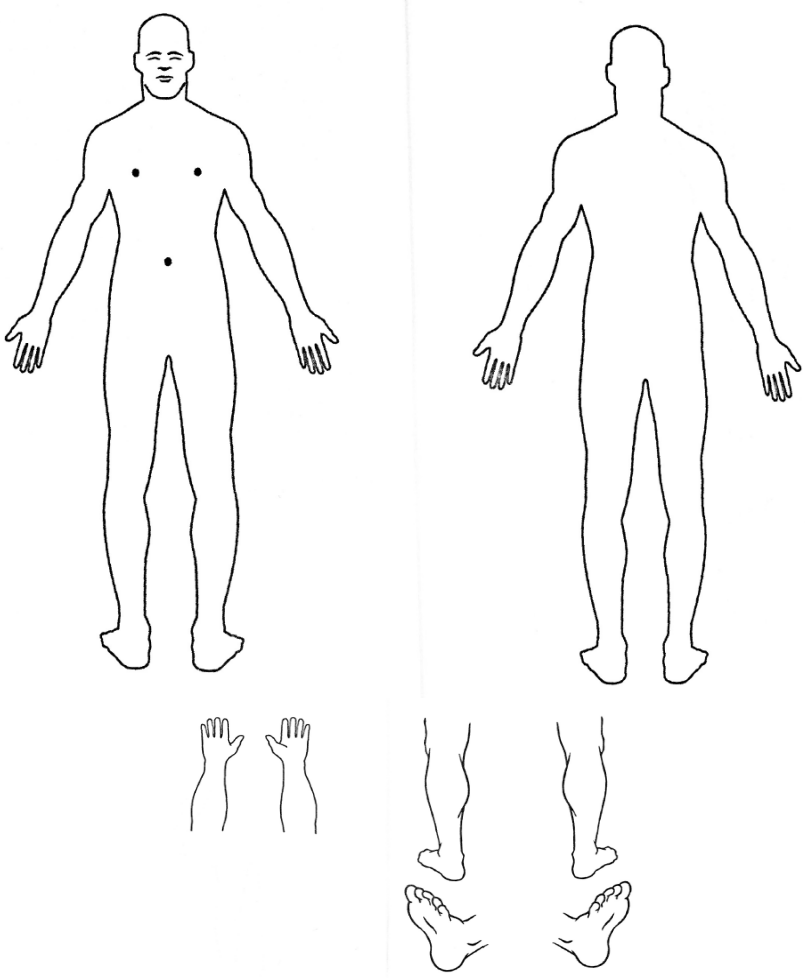
Please check all that apply:

- ☐ Aching Pain
- ☐ Arm/Shoulder
- ☐ Back Pain/Stiffness
- ☐ Chest Wall Pain
- ☐ Dizziness
- ☐ Ear Ringing/Buzzing
- ☐ Fainting
- ☐ Fatigue
- ☐ Foot/Toe
- ☐ Forgetfulness/Memory Loss
- ☐ Hand/Finger
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw Pain
- ☐ Leg Pain
- ☐ Nausea/Vomiting
- ☐ Neck Pain/Stiffness
- ☐ Numbness/Weakness
- ☐ Pressure/Swelling
- ☐ Shooting/Burning Sensation
- ☐ Shortness of Breath
- ☐ Sleep Difficulties
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision Blurred
- ☐ Other:

_____

_____

Please indicate with an **X** on the picture below the areas of complaint:



Patient/Responsible Party Signature: _____ **Date:**_____/_____/_____

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