Auto Accident INTAKE DATA

Workers comp patients must thoroughly complete this form ***no later than 24 hours prior*** to first consultation/treatment with your practitioner/acupuncturist. Please consult with your insurance adjuster to obtain this information. Our Fax Number is 651-683-2906 for form submission.

PERSONAL INFORMATION

Today's date:

Last name / Full First name / Middle name:

DOB:

Home Address / City / State / Zip

Phone (cell) / Phone (home) / Phone (work)

Spouse/Partner Name / Phone (cell)

Primary care physician / Phone / Address

Auto ACCIDENT Needed Information:

Date of Accident

Time of Accident

Location of Accident

City/State of Accident

Description of Accident

INSURANCE Information:

Policy number

Claim number

Name of Insurance Adjuster

Adjuster's phone number

MEDICAL CARE:

Did you go to the hospital? If yes, when? Immediately / hours later / days later

Which hospital?

How were you transported to the hospital? Ambulance / Drove self

How long was your stay at the hospital?

How did the hospital care for your injuries? List all that pertains:

collar / splints / Xrays/MRI / medication / surgery / therapy

Which areas were Xrayed/MRI?

What was the diagnosis

What did they recommend for follow-up care?

Was any other doctor consulted after your accident? If yes, please provide information here:

Dr.

Specialty

Date of initial visit

Type of treatment

Are you still receiving treatment / How often?

Have you retained an attorney? If so, please provide: Name / Phone / Email / Address

Worker's Occupational Information

Job involves..... sitting / standing / How long per day?

Lifting in lbs?

Bending

Twisting

Turning

Stooping

Physical Activity at work

Sedentary

Light, Manual Labor

Manual Labor

Intense Manual Labor

Have you missed any time from work due to the accident? Yes / No If yes, how many days?

Dates of work missed:

Are your work activities restricted because of the accident? Yes / No If yes, explain in detail.

Do any of your work activities aggravate your current complaints

***Please place checkmark next to all that apply...

PHYSICAL PAIN:

Headache

Head feels too heavy

Migraine

Sinus Pain

Fever

Chest pain

Neck pain

Shoulder pain

Upper back pain

Mid back pain

Lower back pain

Arm / Elbow pain

Wrist / Hand pain

Leg pain

Knee pain

Foot / Ankle pain

Sore Muscles

INTERNAL:

Digestive Issues

Menstrual problems

Urinary problems

Stomach / Vomiting / Reflux

Difficulty swallowing

Constipation

SENSATIONS:

Buzzing in Ears

Dizziness

Cold hands and/or feet

Numbness Tingling

Loss of smell

Joint Pain/Stiffness

Jaw pain/Clicking

Sciatica or Pinched nerve, location

Paralysis

Fainting

Loss of Balance

Feeling of "Pins & Needles”

Sensitivity to light/Noise

Vision problems

Loss of Sleep / Sleep disturbance

EMOTIONAL:

Depression

Fatigue

Loss of memory

Irritability

Anxiety

Tension

Nervousness

Specific Areas of Complaint:

1st Body part

Date symptom first appeared

How often do you experience these symptoms

Constant 100% / Frequent 75% / Intermittent 50% / Occasional 25% / Rarely 10%

What makes these symptoms increase

What makes these symptoms decrease

Types of pain

Sharp / Dull / Aching / Burning / Throbbing / Tingling / Numbness / Other

Rate the intensity of your symptoms (0 being no pain, 10 being extreme pain)

If the pain radiates, where does it radiate to?

2nd Body part

Date symptom first appeared

How often do you experience these symptoms

Constant 100% / Frequent 75% / Intermittent 50% / Occasional 25% / Rarely 10%

What makes these symptoms increase

What makes these symptoms decrease

Types of pain

Sharp / Dull / Aching / Burning / Throbbing / Tingling / Numbness / Other

Rate the intensity of your symptoms (0 being no pain, 10 being extreme pain)

If the pain radiates, where does it radiate to?

3rd Body part

Date symptom first appeared

How often do you experience these symptoms

Constant 100% / Frequent 75% / Intermittent 50% / Occasional 25% / Rarely 10%

What makes these symptoms increase

What makes these symptoms decrease

Types of pain

Sharp / Dull / Aching / Burning / Throbbing / Tingling / Numbness / Other

Rate the intensity of your symptoms (0 being no pain, 10 being extreme pain)

If the pain radiates, where does it radiate to?

Other Body Party affected:

Please provide other additional information: