PALM BEACH PHYSICAL MEDICINE

WEST PALM BEACH (Palm Beach Physical Medicine)
3111 45th Street, Ste. 4, West Palm Beach, FL 33409
P: 561-530-4655 • **F:** 561-530-4689
Mon./Tues./Wed./Fri. 9am–1pm & 3pm–7pm
Thurs. 3pm–7pm

Personal Injury Intake Form and Care Agreement

File Number ( )

Patient Information:

Today's Date _____
Name _____ Home Phone _____
I prefer to be called _____ Cell Phone _____
Address _____ Email _____
_____ Social Security # _____
_____ Date of Birth _____
Sex ☐ **Male** ☐ **Female** Height ____' ____" Weight _____ lbs
Occupation _____ Marital Status _____
Employer _____ No of Children _____
Address _____
If minor, name of parent or guardian _____
Who should we contact in case of an emergency? _____
Relation _____ Phone _____
Address _____
Attorney: _____ _____
Primary Care Physician _____ Phone _____
_____
Have you ever been to a chiropractor before? ☐ **YES** ☐ **NO** If so, whom? _____

Health Insurance Information:

Insurance Company _____ Policy number _____
Policy Holder's Name _____ Social Security # _____
Address _____ Phone _____

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** Make/model of vehicle you were in _____
Please explain in detail how the accident occurred _____
_____
Please list symptoms felt immediately after the accident _____
_____
In which direction were you headed? ☐ **N** ☐ **S** ☐ **E** ☐ **W** Approx. speed of vehicle ____MPH

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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?
Were you the ☐ **DRIVER** ☐ **FRONT SEAT PASSENGER** ☐ **BACK SEAT PASSENGER**?
Were you wearing a seat belt? ☐ **SHOULDER HARNESS** ☐**LAP HARNESS**
Was the vehicle equipped with air bags? ☐ **YES** ☐ **NO** Did they inflate? ☐ **YES** ☐ **NO**
Were your brakes? ☐ **applied** ☐ **partially applied** Hands on wheel? ☐ **BOTH hands** ☐ **ONE hand**
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-Injury Information:
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** An MRI? ☐ **YES** ☐ **NO** CAT scan? ☐ **YES** ☐ **NO**
Was medication prescribed? ☐ **YES** ☐ **NO** If yes, what? _____
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**
Indicate the symptoms that are a result of this accident:

☐**DIZZINESS**	☐**DIFFICULTY SLEEPING**	☐**JAW PROBLEMS**	☐**NAUSEA**
☐**MEMORY LOSS**	☐**ARM/SHOULDER PAIN**	☐**IRRITABILITY**	☐**BACK PAIN**
☐**HEADACHE(S)**	☐**NUMB HANDS/FINGERS**	☐**FATIGUE**	☐**LOW BACK PAIN**
☐**BLURRED VISION**	☐**TENSION**	☐**CHEST PAIN**	☐**BACK STIFFNESS**
☐**BUZZING IN EAR**	☐**NECK PAIN**	☐**SHORT BREATH**	☐**LEG PAIN**
☐**EARS RINGING**	☐**NECK STIFF**	☐**STOMACH UPSET**	☐**NUMB FEET/TOES**

☐**OTHER**_____
Did you ever experience similar symptoms prior to the accident? ☐**YES** ☐**NO**
Has your condition ☐ **IMPROVED** ☐ **WORSENED** or ☐ **STAYED SAME** since the accident?
Is your condition affecting your ☐ **WORK** ☐ **SLEEP** or ☐ **DAILY ROUTINE**?Please explain _____
_____
Please indicate your degree of difficulty (on a scale of 1-10, with 1 being comfortable, 5 being uncomfortable, and 10 being painful) in performing the following activities: overall daily function __/10

___ Lying on Back	___ Lying on Side	___ Lying on stomach	___Sitting
___ Standing	___ Stretching	___Lovemaking	___Walking
___ Running	___ Sports	___ Working	___Lifting
___ Bending	___ Kneeling	___ Pulling	___Reaching

How many hours are in your normal workday? _____

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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**

What positions can you work in with minimum physical effort, and for how long? _____
Do you work with others who can help you with any heavy lifting? ☐ **YES** ☐ **NO**
While in recovery, are there any light duty tasks you could request? ☐ **YES** ☐ **NO**

Health History

Have you ever had any of the following diseases or conditions?

☐**HEART ATTACK or STROKE**	☐**HEART SURGERY or PACEMAKER**	☐**HEART MURMUR**
☐**CONGENITAL HEART DEFECT**	☐**MITRAL VALVE COLLAPSE**	☐**ARTIFICIAL VALVES**
☐**ALCOHOL/DRUG ABUSE**	☐**VENEREAL DISEASE**	☐**HEPATITIS**
☐**HIV/AIDS**	☐**SHINGLES**	☐**CANCER**
☐**FREQUENT NECK PAIN**	☐**EMPHYSEMA**	☐**ANEMIA**
☐**HIGH/LOW BLOOD PRESSURE**	☐**PSYCHIATRIC PROBLEMS**	☐**RHEUMATIC FEVER**
☐**SEVERE/FREQ. HEADACHES**	☐**KIDNEY PROBLEMS**	☐**ULCERS/COLONITIS**
☐**FAINTING/SEIZURE/EPILEPSY**	☐**SINUS PROBLEMS**	☐**ASTHMA**
☐**DIABETES**	☐**DIFFICULTY BREATHING**	☐**TUBERCULOSIS**
☐**LOWER BACK PROBLEMS**	☐**ARTIFICIAL BONES/JOINTS**	☐**ARTHRITIS**

Please list **any other** medical conditions that you have or have ever had. _____
_____
Please list any allergies. _____
_____
Please list previous surgeries and dates. _____
_____
Please list any past motor vehicle accidents or traumas and _____
_____
Is there anything else about your health history or family health history that you feel is important to share? _____
_____

Do you exercise? ☐ **YES** ☐ **NO**
Are you on a special diet? ☐ **YES** ☐ **NO** Since: / /
Do you smoke? ☐ **YES** ☐ **NO** How much? _____ How long? _____
Are you wearing: ☐ **ORTHOTICS** ☐ **HEEL LIFTS** ☐ **ARCH SUPPORTS**

For women: Are you taking birth control? ☐ **YES** ☐ **NO**
Are you pregnant? ☐ **YES** ☐ **NO** How long? _____ Nursing? ☐ **YES** ☐ **NO**

Patient/Legal Guardian Signature _____ **Date** _____