

CLIENT INTAKE - PERSONAL INJURY

DATE: _____ / _____ / _____

FILE #: _____

NAME: _____
(FIRST) (MIDDLE) (LAST)

PRESENT ADDRESS: _____
(NUMBER) (STREET) (APT #)

(CITY) (STATE) (ZIP)

PHONE: () ()
(HOME) (WORK)

YOUR DATE OF BIRTH: _____ / _____ / _____ SSN # _____

HEALTH, AUTO, EMPLOYMENT OR OTHER MEDICAL INSURANCE COVERAGE (include policy number, amount of deductible, if any):

EMPLOYMENT INFORMATION:

EMPLOYED BY: _____

SUPERVISOR'S NAME: _____

OCCUPATION: _____ SALARY: \$ _____
(MONTH/WEEK)

STREET ADDRESS: _____
(NUMBER) (STREET) (SUITE #)

(CITY) (STATE) (ZIP)

TELEPHONE NUMBER: _____

DID YOU LOSE/EXPECT TO LOSE TIME FROM WORK AS A RESULT OF ACCIDENT?

YES _____ NO _____

NUMBER OF DAYS MISSED OR APPROXIMATE NUMBER OF DAYS YOU EXPECT TO MISS:

_____ .

ACCIDENT INFORMATION:

DATE OF ACCIDENT: _____ TIME: _____ A.M. _____ P.M. _____

IF AUTO ACCIDENT WERE YOU:

DRIVER: _____ PASSENGER: _____ FRONT SEAT: _____ BACK SEAT: _____ BICYCLE: _____
PEDESTRIAN: _____ NUMBER OF PEOPLE IN THE VEHICLE: _____

PLACE OF ACCIDENT: _____

HOW DID ACCIDENT HAPPEN? DESCRIBE BRIEFLY: _____

WHERE WERE YOU GOING? _____

PHOTOGRAPHS TAKEN AT THE SCENE OF VEHICLE? YES _____ NO _____

WERE POLICE CALLED? YES _____ NO _____

IF YES, WAS IT: HIGHWAY PATROL _____ METRO _____ NLV _____

WAS A REPORT TAKEN? YES _____ NO _____

TICKET GIVEN TO: YOU/YOUR DRIVER _____ OTHER DRIVER _____ NONE _____

CITATION CHARGED: _____

VEHICLE INFORMATION:

YEAR: _____ MAKE: _____ MODEL: _____ COLOR: _____

LICENSE PLATE NO.: _____ TOWED?: YES/NO WHERE: _____

INJURY INFORMATION:

IF TAKEN TO HOSPITAL, NAME OF HOSPITAL: _____

IF TAKEN BY AMBULANCE, NAME OF AMBULANCE: _____

DESCRIBE YOUR INJURIES: _____

IMPORTANT: ARE YOU PRESENTLY OR HAVE YOU EVER BEEN A MEDICARE/MEDICAID RECIPIENT? _____ YES _____ NO. IF YES, PLEASE PROVIDE COPY OF CARD.

TREATING PHYSICIAN(S), CHIROPRACTOR(S) OR PHYSICAL THERAPIST(S):

NAME

ADDRESS

1. _____
2. _____

***** STOP HERE - TELL THE RECEPTIONIST THAT YOU ARE FINISHED *****