

## Personal Injury Intake Form

### Patient Information

Date: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_  
Name: \_\_\_\_\_ Social Security: \_\_\_\_~\_\_\_\_~\_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip  
Email Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Gender: \_\_\_\_\_ Height: \_\_\_\_\_" Weight: \_\_\_\_\_ lbs  
Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Street City State Zip  
Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_  
Emergency Contact Phone Number: \_\_\_\_\_  
If under 18 years, name of Parent or Guardian: \_\_\_\_\_  
PCP Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
How did you hear about our office ?  Website  Gym member  Walk in  Yellow  
pages  Friend/Former patient \_\_\_\_\_  Doctor \_\_\_\_\_  
 Other \_\_\_\_\_

### Accident Information

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM Was it reported?  YES  NO  
Town accident occurred in: \_\_\_\_\_ Street: \_\_\_\_\_  
Please explain in detail how the accident occurred: \_\_\_\_\_  
\_\_\_\_\_  
Please list symptoms felt immediately after the accident: \_\_\_\_\_  
\_\_\_\_\_  
Were you in a work vehicle at the time of the accident?  YES  NO  
Were you the  DRIVER  FRONT SEAT PASSENGER  BACK SEAT PASSENGER?  
Were you wearing a seat belt?  SHOULDER HARNESS  LAP HARNESS  
Where were you taken after the accident? \_\_\_\_\_  
If hospital, how were you taken?  AMBULANCE  PRIVATE VEHICLE  OTHER  
Were X-Rays done?  YES  NO An MRI?  YES  NO CAT scan?  YES  NO  
Have you seen any other doctor(s) since the accident?  YES Name \_\_\_\_\_  NO  
Have you missed any work since the accident?  YES  NO Date(s) \_\_\_\_\_  
Did you ever experience similar symptoms prior to the accident?  YES  NO  
Has your condition  IMPROVED  WORSENERD or  STAYED SAME since the accident?  
Please share any other information that might be important to your diagnosis and  
treatment: \_\_\_\_\_

**Signature (Parent/Guardian of Minor):** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_\_\_



Milton Chiropractic  
& Rehabilitation  
INCORPORATED

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## Acknowledgement of Office Policies

*The following are Bay State Physical Therapy and Milton Chiropractic & Rehabilitation's policies governing appointment scheduling, payment terms, and information releases. **Please read carefully** and be sure to ask questions you might have before signing the document.*

**Appointment Scheduling:** We at Bay State Physical Therapy and Milton Chiropractic & Rehabilitation are glad to accept insurance assignment on your behalf in handling your personal injury or worker's compensation claim. 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. We require a 24 hour cancellation notice for all appointments. If you miss three (3) appointments in a three (3) week period without notifying Bay State (emergencies considered), you may be dismissed from care and your file may be closed.

**Consent for Treatment:** I, the undersigned, give Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation my permission to evaluate and treat my injury. I further understand that in the course of recommended treatment, condition may worsen on rare occasions. I further understand that no guarantee or promise has been made to me concerning the results of treatment. I further understand that the gym and/or pool areas are common areas accessed by patients, gym members and guests and as a result there may be incidental contact with personal health information.

**Assignment of Payment:** I hereby authorize my insurance company and/or my attorney to pay direct to Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation any monies due on my account for professional services rendered.

**Acknowledgment 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 have read and fully understand Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation's Notice of Information Practices. I understand that Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation 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, 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 Bay State Physical Therapy and/or Milton Chiropractic & Rehabilitation 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 instruct the release of all medical, hospital, or surgical records pertinent to my case, including but not limited to exams, special test, 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.

Patient Signature (Parent/Guardian of Minor): \_\_\_\_\_ Date: \_\_\_\_\_  
Name (Please Print): \_\_\_\_\_ DOB: \_\_\_\_\_

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## Designate Individuals Authorization Form

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Please give the name(s) of the individual(s) who you will allow to receive any part(s) of your health record.

Authorized Designees:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name

\_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature (Parent/Guardian of Minor)

## Medical History Form

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_\_\_

Occupation: \_\_\_\_\_ Gender: \_\_\_\_\_ PCP: \_\_\_\_\_

Referring Physician (MD): \_\_\_\_\_ Next appointment w/ referring MD: \_\_\_/\_\_\_/\_\_\_\_\_

**Please answer the following questions:**

What injury or condition brings you here today? \_\_\_\_\_

When did you first notice your condition (date of onset)? \_\_\_\_\_

How did this injury occur? \_\_\_\_\_

Is your condition due to a motor vehicle accident?  Yes  No If yes, date of accident? \_\_\_\_\_

Have you had any falls in the past 12 months?  Yes  No If yes, how many times? \_\_\_\_\_

Did the fall(s) result in injury?  Yes  No If yes, please describe: \_\_\_\_\_

Please describe above: \_\_\_\_\_

Are you seeing (or have you been seen by) any other specialists for your current condition (e.g.: doctor, psychologist, chiropractor, physical therapist, etc.)? Please list: \_\_\_\_\_

Have you been treated by another physical therapist/chiropractor in the past for this or any other condition?

Yes  No

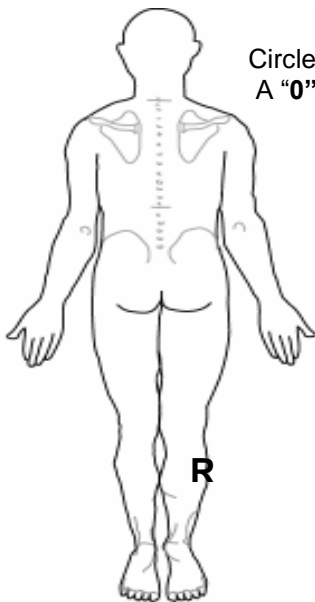
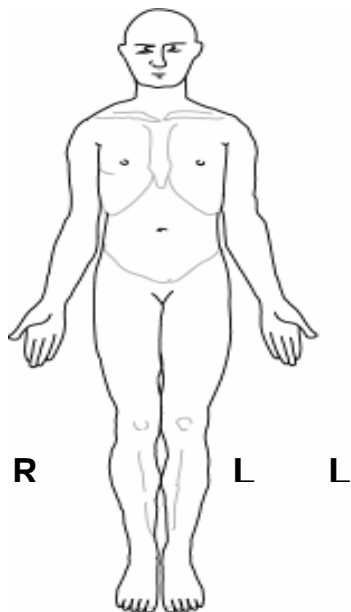
If Yes, by whom/when? \_\_\_\_\_

What tests have you had for this condition?  X-ray  MRI  CT scan  Other: \_\_\_\_\_

**Please mark where you have symptoms on the picture below.**

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

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



Location: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

Location: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

Location: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

Location: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

Since this condition began your symptoms have:  decreased  not changed  increased

Your symptoms are worse in the:  morning  afternoon  night  same all day

What are your goals for treatment? \_\_\_\_\_

**Please list past surgeries/conditions/hospitalizations (or you may attach a separate list):**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Please list all medications, dosage, frequency and route (or you may attach a separate list):**

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_

**Have you ever been diagnosed and/or treated for any of the following conditions (circle all that apply):**

**CONSTITUTIONAL**

Weight Loss

Fatigue

Fever

**EYES**

Glasses/Contacts

Eye Pain

Double Vision

Cataracts

**CARDIOVASCULAR**

Murmur

Chest Pain

Palpitations

Fainting/Spells

Short of Breath

Difficulty Lying Flat

Swelling in Ankles

Pacemaker/Defibrillator

**ENDOCRINE**

Loss of Hair

Heat Intolerance

Cold Intolerance

Diabetes Type I or II

**ALLERGIC**

Hives/Eczema

Hay Fever

**PSYCHIATRIC**

Anxiety

Depression

Mood Swings

Difficulty Sleeping

**RESPIRATORY**

Cough

Coughing Blood

Wheezing

Chills

**GASTROINTEST**

Heartburn/Reflux

Nausea/Vomiting

Constipation

Change Bowel Mvts

Diarrhea

Jaundice

Abdominal Pain

Black/Bloody Bowel Mvts

**GENITOURINARY**

Burning/Frequency

Nighttime

Blood in Urine

Erectile Dysfunction

Bladder Leakage

Abnormal Leakage

**HEMATOLOGY/LYMPH**

Bruise Easily

Gums Bleed Easily

Enlarged Glands

**MUSCLE/BONE**

Joint Pain/Swelling

Stiffness

Muscle Pain

Bone Pain

**SKIN**

Rashes/Sores

Lesions

Itching/Burning

**NEUROLOGICAL**

Loss of Strength

Numbness

Headaches

Tremors

Memory Loss

**CANCER**

Date of diagnosis: \_\_\_\_\_

Location: \_\_\_\_\_

Status: \_\_\_\_\_

**FEMALES ONLY**

Age Onset of Periods \_\_\_\_\_

Periods Regular? Yes/No

Age Onset of Menopause \_\_\_\_\_

Number of Pregnancies \_\_\_\_\_

Please list any allergies that you have (For example: medications, latex, food, bee stings): \_\_\_\_\_

Is there any additional information? \_\_\_\_\_

The above information is true to the best of my knowledge:

Signature (Parent/Guardian of Minor): \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_