

PI INTAKE FORM

Patient: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _(_____)_____ Work Phone: _(_____)_____

Nearest Relative (not living with you): _____

Relation: _____ Phone: _____

Birth Date: _____ SS #: _____

Attorney: _____ Attorney's Phone: _(_____)_____

Employer: _____ Employer's Phone: _(_____)_____

Union Member: () YES () NO Which Union: _____

Physical Complaints: _____

Date Symptoms Began: _____

() Auto Accident () Slip & Fall () Other: _____

Seat Belt Worn? () YES () NO Make of Vehicle: _____

Date of Incident: _____ Time: _____ City: _____

Was a Police Report Filed? () YES () NO Driver: () YES () NO

Any Time Missed From Work? () YES () NO How Much Time: _____

Is This Your First Auto Accident in 5 Years? () YES () NO

Are You Presently Treating For A Work Injury? () YES () NO

HOSPITAL CARE: () YES () NO Emergency Care At: _____

Hospitalized At: _____ Inpatient () Outpatient ()

X-rays Taken? () YES () NO Medications Given? () YES () NO

Allergies To Medication? _____

Name Of Medications Given/Taken At Present: _____

Patient Name: _____

1. The Patient was a (driver / front seat passenger / back seat passenger / operator)

Other _____

2. In a (automobile / bus / truck / motorcycle) (make / year / color of vehicle)

Other _____

3. Traveling (north \ south \ east \ west) on what street _____

4. Name of city _____

5. Date and time of day. (AM / PM) _____

6. How many other occupants were in the car? _____ How many were injured? _____

7. Struck or hit from (behind \ right side \ left side \ front)

Other _____

8. By a (automobile / bus / truck / motorcycle) (make / year / color of vehicle)

Other _____

9. Other vehicle traveling (north \ south \ east \ west) on what street _____

10. Accident happened at or near (corners of / street name / freeway exit) _____

11. Police report filed? (YES / NO) Date _____ (need copy)

Set up of accident _____

12. The patient's vehicle (pushed further forward / sideways / to the left / to the right / spun around)

Other _____

13. Throwing patient (forward / into steering wheel / dash board / windshield / left door / right door / other occupants)

Other _____

14. The other vehicle proceeded to _____

15. On second impact the patient was thrown ((forward / into steering wheel / dash board / windshield / left door / right door / other occupants) **list in order of occurrence**

16. Patient taken to (Emergency Care Ctr / Hospital) By (car / ambulance) When _____

17. Other occupants taken to Hospital? (Yes / No) By (car / ambulance) When _____

18. Symptoms immediately following accident _____

19. Previous auto accident (Yes / No) When _____

20. Previous back or neck injuries (Yes / No) When _____

Where _____

Treatment _____

21. Other pertinent information _____

PATIENT SIGNATURE: _____