Twin Creeks Health – Personal Injury Intake Form

Name_____
Date_____

Address_____ City_____
State____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

Social Security_____ Email address: _____

DOB_____ Age_____ Sex_____ Number of children:_____
Status M S W D

Employer Name_____
Occupation_____

Emergency Contact_____
Phone_____

Person responsible for this account_____
Referred By _____

Your Ins. Co. _____
Phone #_____Policy #_____

Name on policy (if other than self):_____
Claim#_____

ATTORNEY

Name_____ Phone ( ) _____

Address_____ City _____
State_____ Zip _____

NATURE OF ACCIDENT

Date of accident _____ Time of day_____
Location_____

Were you the: ___ Driver ___Passenger ___ Front Seat ___ Back Seat
Number of people in your vehicle _____

Were you struck from: ____ Behind ____Front ____Left Side ____ Right Side
Approximate speed _____mph

Approximately how much damage was done to your car? $ _____ Was your car totaled? ____ Yes ____ No

Were you knocked unconscious? ___Yes ___No If yes, for how long?_____ Were the police notified? ___Yes___No

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Were you hospitalized? ___ Yes ___ No If yes, were and for how long?
_____

In your own words, please describe the accident:
_____
_____

What are your present complaints?
_____
_____

Did you have any physical complaints BEFORE the accident? ___ Yes ___ No If yes, describe _____
_____
_____

Since this injury occurred, are your symptoms: ____ Improving ____Getting Worse ____ Same

Have you been treated by another doctor since the accident? ___ Yes ___ No
If yes, where and when_____
_____

Have you lost time from work as a result of this injury? ___ Yes ___ No
If yes, how long? _____

Do you notice any activity restrictions as a result of this injury?
____ Yes ____ No If yes, please describe in detail:

_____
_____
_____
_____
_____
_____

Other pertinent information:
_____
_____
_____
_____
_____
_____

Patient Signature _____

Date_____