CERRITOS CHIROPRACTIC CENTER

Personal Injury Intake Form and Chiropractic Care Agreement

Patient Information:

Date:_____ Home Phone:_____

Name:_____ Cell Phone:_____

Address:_____ Work Phone:_____

_____ Date of Birth:_____

Occupation:_____ Email:_____

Employer:_____ Sex: M/ F

Marital Status: Single/ Married/ Other

Health Insurance Information:

Patient is: Primary insurance holder/ Dependent

Name:_____ Date of Birth:_____

Insurance Carrier:_____ Member ID Number:_____

Auto Insurance Information:

Insurance Company:_____ Policy Number:_____

Adjuster Name:_____ Claim Number:_____

Phone Number:_____ Med pay: Y/ N

Third Party Information:

Name:_____ Phone Number:_____

Insurance Company:_____ Claim Number:_____

Adjuster Name:_____ Adjuster Phone Number:_____

Attorney Information:

Attorney Name:_____ Phone Number:_____

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Accident Information:

Date:_____Time:_____AM/ PM Was it reported to the police? Y/ N

Location of Accident:_____ Number of Passengers:_____

Make/ Model of vehicle you were in_____

Please explain in detail how the accident occurred_____

_____

Please list any symptoms felt immediately after the accident_____

_____

In which direction were you headed: **N/ S/ E/ W**

In the past week, how much has your pain interfered with your daily activities? (e.g., work, social activities, or household chores?)

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on activities

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No

☐ Yes : Date(s) taken: _____ What areas were taken? _____

Please check all of the following that apply to you:

☐ Recent Fever ☐ Prostate Problems
☐ High Blood Pressure ☐ Urinary Problems
☐ Corticosteroid Use (cortisone, prednisone, etc)
☐ Dizziness/ Fainting ☐ Visual Disturbances
☐ Pain unrelieved by Position or Rest
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (explain) _____

☐ Diabetes ☐ Menstrual Problems
☐ Stroke(Date) _____ ☐ Taking Birth Control Pills
☐ Currently Pregnant: # weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness ☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____

☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (explain) _____

☐ Medications _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges of services rendered and I agree to notify this doctor immediately whenever I have charges in my health condition or health plan coverage in the future.

Patient Signature_____ Date_____