



PATIENT INTAKE FORM - PLEASE PRINT

PERSONAL INFORMATION

NAME _____ EMAIL _____
FIRST MIDDLE - MAIDEN LAST

DATE OF BIRTH _____ GENDER _____ MARITAL STATUS _____
MONTH / DAY / YEAR SINGLE / MARRIED / DIVORCED

MAILING ADDRESS _____
NUMBER & STREET CITY STATE ZIP

PHONE _____ SOCIAL SECURITY NO. _____

Our practice uses text messages to communicate with our patients. We will use text messaging to communicate your next appointment date and office closures. We will never disclose medical information via text message. By providing your cell phone number and signature, you agree to receive text messages from Brandon Injuyr and Wellness Center. *Data plan charges may apply*:

CELL PHONE NO. _____ PATIENT SIGNATURE _____

EMERGENCY CONTACT

NAME _____
FIRST MIDDLE MAIDEN LAST

RELATIONSHIP _____

PHONE _____

ATTORNEY INFORMATION

Name: _____

PHONE _____

DATE OF ACCIDENT _____

AUTO INSURANCE INFORMATION

NAME OF INSURED _____
FIRST MIDDLE MAIDEN LAST

EFFECTIVE DATE _____ RELATIONSHIP TO INSURED _____
MONTH / DAY / YEAR

NAME OF AUTO INSURANCE COMPANY _____

HAS ACCIDENT BEEN REPORTED YES NO CLAIM NO. _____ POLICY NO. _____



PLEASE PRINT

PAST MEDICAL HISTORY

Besides this accident **I have / have not** been in any other accidents. If so, when? _____

There **were / were not** injuries.

Explain injury, if applicable: _____

I was treated by: _____

I was / was not still under care for those injuries at the time of this current accident with Dr. _____

Have you had any of the following illnesses? Check all that apply.

- | | | | |
|------------------------------------|--------------------------|---|----------------------------|
| Alcohol Overdose | Emphysema | Kidney Disease | Seizures |
| Allergies (other than medications) | Epilepsy | Kidney or Bladder Infections (frequent) | Stomach Pain |
| Anemia | Gallbladder Disease | Lung Disease | Stomach Ulcer |
| Asthma | Goiter | Lung Infections (frequent) | Stroke |
| Bleeding Tendency | Gout | Other Medical Problems: _____ | Swollen Joints |
| Cancer Type: _____ | Hay Fever | Nausea | Thyroid Disease |
| Chest Pain | Headaches: Migraine | Nervous Breakdown | Tuberculosis |
| Chronic Fatigue | Sinus Tension | Pacemaker / Stents | Urinary Problems |
| Colitis | Hearing Problems | Polio | Vision Problems |
| Congenital Heart Disease | Heart Attack | Rashes | Childhood Diseases: |
| Constipation | Heart Disease | Sexually Transmitted: | Chicken Pox |
| Depression | Hepatitis A B C | AIDS, Syphilis, HIV | Measles |
| Diabetes: Type 1 / Type 2 | High Blood Pressure | Gonorrhea, Herpes | Mumps |
| Diarrhea | Intestinal Polyps | Shortness of Breath | Rheumatic Fever |
| Difficulty Swallowing | Irregular Heart Beat | Sickle Cell Anemia | Whooping Cough |
| Dizziness | Irritable Bowel Syndrome | | |
| | Jaundice | | |

Any other past medical history the doctor should know? _____

HOSPITALIZATIONS

Reasons & Approximate Dates: _____

I have / have never had surgery. Name procedures and dates: _____

Any surgical implants? YES NO If so, please describe. _____

Any allergies? _____

Current medications? _____

Are you pregnant? YES NO (If applicable)



ACCIDENT QUESTIONNAIRE

PATIENT DETAILS

Accident/Injury Type Auto Slip/Fall On the Job Other: _____

Were you wearing a seatbelt? Yes No Did the airbags deploy? Yes No

You were the Driver Passenger - Front seat Back seat

In your own words, please describe the accident/injury _____

Were you struck in the Front Rear Driver's side Passenger's side

Were you knocked unconscious? Yes No

Were you examined by paramedics, EMT or any other first responder after the accident? Yes No _____

Did you go to the hospital? Yes No If yes, name of Hospital _____

Drivin to the Hospital by Ambulance Self Other

Were you given medication? Yes No

Have you been treated since the accident? Yes No If yes please include doctor's name, address, and treatment below

Name _____ Address _____
NUMBER & STREET CITY STATE ZIP

Describe treatment _____

Have you ever had similar symptoms prior to the accident/injury? Yes No If yes please describe

REVIEW OF SYSTEMS

Do you currently have any of the following? Check all that apply.

- | | | | | |
|---------------------|------------------|------------|-----------------------|----------------|
| Headaches | Stomach Pain | Chest Pain | Vision Problems | Nausea |
| Shortness of Breath | Hearing Problems | Vomiting | Urinary Problems | Dizziness |
| Constipation | Rashes | Diarrhea | Difficulty Swallowing | Swollen Joints |
| Chronic Fatigue | | | | |



PATIENT INJURY IDENTIFICATION

SELECT ALL SYMPTOMS THAT APPEARED AS A RESULT OF YOUR ACCIDENT/INJURY

MENTAL HEALTH: ANXIOUS / NERVOUS TO DRIVE / RIDE IN A CAR PANIC ATTACKS / ANXIETY NIGHTMARES DEPRESSION
 IRRITABLE FATIGUE FORGETFULNESS WEIGHT GAIN WEIGHT LOSS
 DIFFICULTY: CONCENTRATING READING WRITING SLEEPING
 MEMORY LOSS: SHORT TERM LONG TERM BOTH

HEAD: HEADACHE BLURRED VISION DIZZINESS RINGING IN EARS
 LOSS OF BALANCE LOSS OF COORDINATION
 LACK OF BALANCE OR DIZZINESS WHEN TURNING HEAD
 PAIN WHEN CHEWING CLICKING SENSATION WHEN CHEWING

NECK: PAIN STIFFNESS HEAVINESS POPPING OR CRUNCHING SENSATION

UPPER BODY: LOSS OF RANGE OF MOTION IN SHOULDERS: LEFT RIGHT BOTH
 PAIN WHEN MOVING SHOULDERS: LEFT RIGHT BOTH
 NUMBNESS/TINGLING DOWN ARM: LEFT RIGHT BOTH
 ELBOW PAIN: LEFT RIGHT BOTH
 WRIST PAIN: LEFT RIGHT BOTH
 NUMBNESS/TINGLING IN HAND: LEFT RIGHT BOTH
 WEAKNESS IN HAND: LEFT RIGHT BOTH

BACK: BACK PAIN FROM PROLONGED PERIOD OF TIME: SITTING STANDING
 TROUBLE BENDING OVER TROUBLE GETTING STRAIGHT AGAIN AFTER BENDING OVER

LOWER BODY: HIP PAIN: LEFT RIGHT BOTH
 PAIN GOING INTO THE BUTTOCKS: LEFT RIGHT BOTH
 GOING DOWN THE LEGS: PAIN NUMBNESS LEFT RIGHT BOTH
 PAIN/ NUMBNESS GOING DOWN THE LEGS TRAVELS INTO: CALF FOOT
 KNEE PAIN: LEFT RIGHT BOTH
 ANKLE PAIN: LEFT RIGHT BOTH

OTHER: BRUISING FROM THE SEATBELT – LOCATION OF BRUISING: _____
 LIST ANY OTHER CUTS, BRUISES, OR ABRASIONS FROM THE ACCIDENT:

 OTHER SYMPTOMS/PROBLEMS NOT LISTED:

 ANY PREVIOUS INJURIES/SURGERIES THAT HAVE BEEN RESOLVED, BUT NOW HAVE BEEN MADE WORSE SINCE THE ACCIDENT:

