Patient Intake Form

Patient Information

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Female: _____ Male: _____

Social Security Number: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell/Other: _____

I prefer to receive calls at (circle) Home/Work/Cell I am (circle) Under Age18/Single/Married/Divorced/Widowed/Separated

Employer: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Payment Information

Person Responsible for Payment: _____

Social Security Number: _____ Phone: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? _____ Yes _____ No

Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Please have your insurance card and driver's license ready so they can be copied for the clinic's records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize [clinic name] to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to [clinic name] and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient

Signed _____ Date _____

Workers' Compensation Questionnaire

Was your accident directly related to your work? ☐Yes ☐No
Briefly describe the events that occurred just before and during your accident:_____

_____

_____

_____

Did you report your accident to your employer? ☐ Yes ☐No
Did accident render you unconscious? ☐Yes ☐No
If yes, for how long?_____

_____

_____

Please describe how you felt immediately after the accident:_____

_____

_____

_____

Describe any treatment you received:_____

_____

_____

_____

Were x-rays taken? ☐Yes ☐No
Was medication prescribed? ☐Yes ☐No
If yes, what type:_____

_____

_____

Are your work activities restricted as a result of this injury? ☐Yes ☐No

Indicate the symptoms that are a result of this accident:

☐Dizziness
☐Difficulty Sleeping
☐Arms /Shoulder Pain
☐Upper/Mid Back Pain
☐Memory Loss
☐Irritability
☐Numb Hands/Fingers
☐Lower Back Pain
☐Headache
☐Fatigue
☐Chest Pain
☐Back Stiffness
☐Blurred Vision
☐Tension
☐Shortness of Breath
☐Numb Feet/Toes
☐Ears Ringing/Buzzing
☐Neck Pain
☐Stomach Upset/Nausea
☐Stiff Neck
☐ Jaw Problems
☐Leg Pain
☐Other:

Is your condition getting worse? ☐Yes ☐No

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Sexual Activity	☐	☐	☐
Walking Short Distance	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Bending Forward	☐	☐	☐
Operating Equipment	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Lifting	☐	☐	☐
Driving	☐	☐	☐
Twisting	☐	☐	☐
Crawling	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Typing	☐	☐	☐
Stooping	☐	☐	☐

Signature: _____ **Date:** _____

Please note this form is to be used in conjunction with any forms required by your state's workers' compensation board. This form is not intended to be a substitute for any state or other authority's forms.