INTAKE FORM

PATIENT INFORMATION

Date: ____________________ *Preferred Language:* __________________ ☐ *Interp.*

Patient Name: ____ Birthdate: ______________ Age: _____
FIRST, MIDDLE, LAST (MM / DD / YYYY)

Nickname: ______________________________ *(the name you prefer to be called, if different)* Gender: ☐ MALE ☐ FEMALE

If the patient is a **CHILD under 18 years old**, enter the child's legal parent/s or guardian information:

Relationship	Name	Birthdate	Phone Number
☐ Father			
☐ Mother			
☐ Guardian/Foster Parent			

Who does child live with? ☐ Father ☐ Mother ☐ Both ☐ Guardian/Foster Parent ☐ Grandparent ☐ Sibling ☐ __________

Patient Address: ____

City / State / Zip: ____

Phone Number: ______________________ E-Mail Address: ______________________

Marital Status: ☐ SINGLE ☐ MARRIED / DOMESTIC PARTNER ☐ DIVORCED ☐ WIDOWED *Number of Children:* _____

Emergency Contact: ***NAME:*** ______________________ ***PHONE:*** ______________

Employment Status: ☐ EMPLOYED FULL TIME ☐ EMPLOYED PART TIME ☐ UNEMPLOYED ☐ RETIRED ☐ HOMEMAKER ☐ STUDENT

Your Occupation: ______________________ Your Employer: ______________________

Work Address: ______________________ Work Phone: ______________

If you are a STUDENT, name of School: ______________________ ☐ Full Time ☐ Part Time

Your Primary Doctor: ______________________ Phone: ______________

Your Attorney (if any): ______________________ Phone: ______________

Who referred you to our clinic? ______________________

Is your condition related to: ☐ an **AUTO ACCIDENT**? ☐ a **WORK-RELATED** injury or cause? ☐ another kind of **INJURY**?

If not an injury, did it start: ☐ GRADUALLY? *(slowly over time)* ☐ SUDDENLY? *(symptoms just appeared)* ☐ CHRONIC? *(had for a long time)*

WHEN did your injury occur or other condition begin? **Enter date:** ______________ *(enter approximate date if exact date unknown)*

WHERE did your injury occur or other condition begin? **Enter location:** ______________________

Describe your symptoms or condition: ____

____

____

Have you ever had the same or similar symptoms or condition? ☐ NO ☐ YES If yes, when? ______________

If yes, describe: ____

____

INTAKE FORM, *continued*

PATIENT INFORMATION

Date: ______________________

Enter the names of any other healthcare providers you have seen for this injury or condition:

Name of Healthcare Provider	Type of Practice *(specialty)*	Date of Last Visit

Please list all medications you are taking now, including over-the-counter medicines *(such as Tylenol, Advil, Ibuprofen, Aspirin)* :

____

(Please note that we must have a list of all medications you are taking. You may attach a separate sheet if more space is needed)

PAST ACCIDENTS, INJURIES, SURGERIES, ILLNESS

List ALL auto accidents, work injuries, sports injuries, other injuries, surgeries and major illnesses you have ever had in the past. *Tell us what body area/s were injured or had surgery (describe the injury or illness), the month & year for each one (if you're not sure, enter your best guess), and tell us whether you recovered fully and if not, what problem/s remain.*

Auto Accident?	Work Injury?	Other Injury?	Surgery?	Serious Illness?	What body area/s & condition/s were involved?	Month/Year	Did you recover fully? *(If not, enter details)*
☐	☐	☐	☐	☐			
☐	☐	☐	☐	☐			
☐	☐	☐	☐	☐			
☐	☐	☐	☐	☐			

Have you ever had any of the following conditions?

☐ Arthritis	☐ Backaches	☐ Digestive Disorders	☐ Heart Trouble	☐ Neuritis
☐ Anemia	☐ Cancer	☐ Dizziness	☐ Hernia	☐ Numbness
☐ Asthma	☐ Diabetes	☐ Headaches	☐ Nervousness	☐ Sinus Trouble

WOMEN'S HEALTH - *For Women Only*

Date of Last Menstrual Period

Are you pregnant? ☐ No ☐ Yes ☐ Unsure If yes, what is your due date? ______________

PATIENT CERTIFICATION

I certify that the information I give on this form and during my examination is true, correct and complete to the best of my knowledge. I will not hold the doctor nor the clinic responsible for any errors or omissions that I may have made in my answers. I understand and agree that the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature ______________ Personal Representative's Signature ______________ Date Signed ______________

Description of personal representative's authority to act for the patient. ______________

Personal Representative's Name *(Printed)* ______________

Staff Witness ______________

DOCTOR'S NOTES: ____

REVIEWED BY:
Doctor's Signature: ______________

☐ Joseph A. Graffeo, DC
☐ Joseph F. Graffeo, DC
☐ Michael T. Malone, DC
☐ Kelley Silon, DC

INTAKE FORM

AUTO ACCIDENT QUESTIONNAIRE

Date: ______________________ Patient Name: ____

ACCIDENT DETAILS

Date of Crash: ______________________ LOCATION: Street Names: ____

(Enter the intersection where the crash occurred or the nearest cross streets to the crash location.)

Time of Crash: _____________ AM / PM

Were you *(mark one)* : ☐ The DRIVER? ☐ A PASSENGER? ☐ A PEDESTRIAN?

If you were **NOT** *the driver:* Driver's Name: ___________________________ Driver's Phone No.: ______________________________

Were you struck: ☐ from Behind (rear-ended) ☐ on the Left side ☐ on the Right side ☐ from the Front (head-on)

At impact, where were you looking? ☐ Straight Ahead ☐ To the Left ☐ To the Right ☐ Looking Up ☐ Looking Down

At impact was your vehicle: ☐ Stopped to make a turn? ☐ Stopped for a traffic signal or pedestrian? ☐ Parked? ☐ Moving?

Were you wearing a seat belt? ☐ Yes ☐ No Did your airbags deploy? ☐ Yes ☐ No If yes, did the airbags hit you? ☐ Yes ☐ No

Did you see or hear the accident coming? ☐ Yes ☐ No If yes, were you braced for the impact? ☐ Yes ☐ No

Describe in detail how the accident happened:

____

____

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DRAW THE ACCIDENT

At the time of the crash, did your **head** or **body** hit any part of the inside of the vehicle? ☐ Yes ☐ No If yes, please describe where:

____

Did you get any **bleeding cuts or bruises** in this crash? ☐ Yes ☐ No If yes, where were they? _________________________________

____

As a result of the accident were you rendered unconscious? ☐ Yes ☐ No If yes, how long were you unconscious? __________________

Did you go to the hospital or see another doctor for your injuries? ☐ Yes ☐ No If yes, when? ___________________________________

How did you get there? ☐ I drove myself ☐ Someone else drove me ☐ An ambulance took me ☐ Other: _________________________

Hospital or doctor's name: ____

(enter the name/s of all hospitals and/or doctors you have seen because of your injuries from this crash)

Have you been x-rayed since the accident? ☐ Yes ☐ No Have you had an MRI since the accident? ☐ Yes ☐ No

Have you lost any days of work because of the accident? ☐ Yes ☐ No If yes, how many days have you lost? _______________________

AUTO ACCIDENT QUESTIONNAIRE

Date: ______________________

Was a police report made for this accident? ☐ Yes ☐ No If yes, give the report to Reception to copy.

Was a ticket or citation written? ☐ Yes ☐ No If yes, who received it? ______________________

Were you in **YOUR OWN** vehicle at the time of this accident? ☐ Yes ☐ No If no, whose vehicle were you travelling in?

☐ Spouse's ☐ Friend's ☐ Parent or Family Member's ☐ Taxi ☐ Commericial Vehicle (truck) ☐ Bus ☐ Other ______________

Vehicle Owner's Name: ______________________ Phone Number: ______________

Was this vehicle insured? ☐ Yes ☐ No If yes, give Reception the insurance card to copy and enter information for **THIS VEHICLE**

Insurance Company Name: ______________________ Phone Number: ______________

Have you reported this accident to **THIS** insurance company? ☐ Yes ☐ No If yes, enter Claim Number: ______________

Insurance Adjuster's Name: ______________________ Phone Number: ______________

Did you tell them you were injured? ☐ Yes ☐ No If no, you need to call them to open a medical claim.

Did the accident involve a **hit-and-run driver**? ☐ Yes ☐ No If no, please provide the information for the **OTHER** vehicle in this accident:

Name of Other Driver: ______________________ Phone Number: ______________

Other Driver's Insurance Co.: ______________________ Phone Number: ______________

Other Driver's Insurance Policy No.: ______________________ Claim Number: ______________

Make of vehicle: ____________ Model: ____________ Year: ______ License Plate No. __________ State: ______

Are you yourself licensed to drive? ☐ Yes ☐ No If yes, give your license to Reception to copy.

Does anyone you live with own another vehicle with auto insurance, or are they insured under another automobile insurance policy?

(Automobile insurance laws in applicable states require this information. Mark all that apply.)

☐ Spouse ☐ Father ☐ Mother ☐ Guardian/Foster Parent ☐ Grandparent ☐ Sibling ☐ Child ☐ None

Have you been contacted by an adjuster from the other driver's insurance company about this claim? ☐ Yes ☐ No If yes, enter information:

Insurance Company Name: ______________________ Phone Number: ______________

Adjuster's Name: ______________________ Claim Number: ______________

Have you signed a settlement agreement for this claim? ☐ Yes ☐ No If yes, was it for: ☐ Property *(vehicle)* Damage? ☐ Medical Expenses?

PATIENT CERTIFICATION

I certify that the information I give on this form and during my consultation is true, correct and complete to the best of my knowledge.
I will not hold the doctor nor the clinic responsible for any errors or omissions that I may have made in my answers.

Patient Signature: ______________________ Date Signed: ______________

DOCTOR'S NOTES: ______________________

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REVIEWED BY:
Doctor's Signature: ______________

☐ Joseph A. Graffeo, DC
☐ Joseph F. Graffeo, DC
☐ Michael T. Malone, DC
☐ Kelley Silon, DC