

# Personal Injury Intake Form

# TIGGES CHIROPRACTIC AND WELLNESS

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of injury: \_\_\_/\_\_\_/\_\_\_/ Time: \_\_\_\_\_ AM / PM

Where did the injury occur? \_\_\_\_\_

Please describe the injury in your own words? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was there anything in particular that you think caused the injury: example: wet floor  
Please describe: \_\_\_\_\_  
\_\_\_\_\_

Immediately after the accident, were you:  Conscious  Dazed  Unconscious  
If dazed or unconscious, how long? \_\_\_\_\_

Did anyone witness your injury?  Yes  No  
Who? \_\_\_\_\_

Did you report the injury to anyone?  Yes  No Who? \_\_\_\_\_

Was the report:  Written  Verbal

Did you go to the hospital?  Yes  No If yes:  Right after the injury  Next day   
Other \_\_\_\_\_

If yes, how did you get there?  Ambulance  Other \_\_\_\_\_

If by ambulance, did the ambulance attendants place you in a:  Neck Brace  Back Brace   
Other \_\_\_\_\_

List any medication or medical supplies given? \_\_\_\_\_

Did you have X-rays taken at the hospital?  Yes  No

If you went to the hospital or saw another doctor, please answer the following:

Hospital Name \_\_\_\_\_ Doctor Name \_\_\_\_\_

Diagnosis \_\_\_\_\_ Treatment received \_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Requirements? \_\_\_\_\_

Have you lost any days of work because of this injury?  Yes  No

If yes, date(s) \_\_\_\_\_

Have you retained an attorney?  Yes  No Litigation?  Yes  No  Maybe

If yes, please give name and address: \_\_\_\_\_

Patients Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_/