## PERSONAL INJURY INTAKE FORM (Other than Motor Vehicle Accident)

DATE OF INCIDENT:	(attach copy of
<mark>olice report)</mark>	
Name:	
Date of Birth:	
Address:	
Telephone Number:	
Social Security Number:	
Health Insurance Company:	
Policy No./Subscriber ID:	
Subscriber's Name:	
ist the name and telephone number (if known)	of all Medical Providers seen:

List the injuries sustained as a result of the incident:

<b>Emp</b>	loyment:
•	Were you employed at the time of the accident?; If so, state the following:
	1. Employer's name, address and telephone number:
	2. Did you have any loss of wages? If so, did you have a doctor's order? If so, state the doctor's name and address:
•	Are you currently employed?:; if so, state the employer's name, address and telephone number, if different from above.
<u>Statu</u>	us of Treatment/Medical Condition:
•	Are you currently treating for your injuries?
•	Have you been released/discharged from treatment?
•	Have you fully recovered from your injuries?; if not, state where you are still experiencing pain and name of the provider who continues to treat you:
•	Do you have any permanent injuries?; if so, explain:
<u>Preex</u>	xisting Medical Conditions:
•	Do you have any preexisting medical conditions, such as back problems etc.?; if so, explain in detail:

•	Have you been involved in any other accident (s) or any other trauma prior to or after the incident described above? If so, explain in detail, describing injuries sustained, when and how the accident or trauma occurred, treatment received etc.
•	List all hobbies you had prior to the incident which you are unable to do now as a result of the injuries sustained in the incident, if any:
EVDI	AIN IN DETAIL HOW THE INCIDENT OCCUPDED (Including where you were
coming the acc	AIN IN DETAIL HOW THE INCIDENT OCCURRED (Including where you were g from and headed to, who was with you, whether you were on your cell phone at the time ident occurred (if so, provide the telephone number), whether you had taken any tion prior to the accident (if so, what, dosage and reason for taking) etc.)

•	LIST ALL TREATMENT YOU HAVE UNDERGONE FOR THE PAST FIVE
	YEARS PRIOR TO THE INCIDENT, STATING THE REASON FOR
	TREATMENT, MEDICAL PROVIDERS SEEN, HOSPITALIZATIONS, NAMES
	OF HOSPITALS, REASON FOR HOSPITALIZATION, AND DATES OF
	TREATMENT OF WHICH YOU HAVE RECOLLECTION (Please provide a list of
	all providers which treated you for the five year period prior to the accident):

PROVIDE YOUR EMPLOYMENT HISTORY FOR THE FIVE YEAR PERIOD

**PRIOR TO AND AFTER THE ACCIDENT** (include the name of your employer, position held and duties and responsibilities of your position).

• STATE WHETHER YOUR SPOUSE WILL BE MAKING A LOSS OF CONSORTIUM CLAIM IN THE EVENT THE MATTER IS LITIGATED (if so, state how the accident has affected your marriage):