# SILVER HEALTH CENTERS

*Chiropractic Physical Medicine, Rehabilitation and Preventive Health Care*
850 S. Greenville Ave., Ste #104 Richardson, TX 75081 972-644-6336 fax 972-644-7247

## Patient Intake Form- MVA

Date_____

**PATIENT INFORMATION**

Last Name_____ First Name _____ S.S.N._____-_____-_____

Gender: M F Age ____ Birth date ____/____/_____ Marital Status: M S D W

Cell Phone_____ Email _____ Home Phone_____

Address_____ City_____ State_____ Zip _____

Employer_____ Occupation_____ Work Phone_____

Emergency Contact Name_____ Relationship_____ Phone Number_____

How were you referred to our office?_____

**PRESENT SYMPTOMS**

Chief complaints:_____

_____

Date complaints began:_____

Have you lost time from work? Y N How many days lost?_____ Dates from _____ thru_____

What aggravates your present symptoms?_____

What makes your present symptoms better? _____

Have you gone to the E.R. for this condition Y N Date_____Hospital_____

Have you seen another doctor for this condition? Y N Date_____ Doctor_____

Have you seen a chiropractor before? Y N If yes, where?_____

**ACCIDENT INFORMATION**

Date of accident_____ Time_____ AM or PM

City_____ # of persons in your vehicle____

Were you the: Driver Passenger Pedestrian

Did your vehicle strike another vehicle after impact? Y N

How many times was your vehicle struck?_____

You were hit from the: Rear Front Right Side Left Side

Were you prepared for impact? Y N

Were you wearing a seat belt? Y N

Who was cited? You The driver of your vehicle The driver of the other vehicle

How fast were you driving at the time of impact?_____mph

Can you please describe the accident?_____

_____

Describe your symptoms immediately after the accident. _____

## HEALTH HISTORY

Do you have any other medical condition? Y N If yes, list below, state if receiving care and where

_____

Are you currently taking any medications? Y N If yes, list medications below

_____

Have you had any recent diagnostic tests (X-Rays, MRI, bloodwork)? Y N If yes, list below and when

_____

Have you had any prior surgeries? Y N If yes, list all below

_____

Have you had any prior motor vehicle accidents or other serious accident? Y N If yes, list and describe below

_____

Did you receive care after those motor vehicle accidents?_____

## MEDICAL HISTORY

Please check below if YOU have a history of:

Heart Disease Cancer Stroke Diabetes Other:_____

Please check below if you have a FAMILY history of:

Heart Disease Cancer Stroke Diabetes Other:_____

## SOCIAL HISTORY

Do you exercise? Y N If yes, how often and what_____

Do you use tobacco? Y N If yes, smokeless or smoke and how often_____

Do you drink alcohol? Y N If yes, how many per week_____

Do you drink coffee? Y N If yes, how many per day_____

Do you take supplements/vitamins? Y N If yes, list_____

## REVIEW OF SYSTEMS

Approximate height:_____ Approximate weight:_____

Place an X in the box of each condition you are currently experiencing or have experienced:

| | | | |
|---|---|---|---|
| Allergies | Neck/Back Pain | Numbness | High Blood Pressure |
| Weight Loss | Headaches | Loss of Sensation | Heart Disease |
| Obesity | Arm/Leg Pain | Confusion | Aneurysm |
| Loss of Appetite | Bone Tumor | Dizziness | Angina |
| Fatigue | Fracture | Slurred Speech | Irregular Heart Beat |
| Anxiety | Low Bone Density | Loss of Balance | Heart Attack |
| Vision Trouble | Hearing Loss | Kidney Infection | Blood in Stool |
| Double Vision | Tinnitus | Loss Bladder Control | Diarrhea |
| Night Blindness | Vertigo | Urine Change | Abdominal Pain |
| Glaucoma | Nose Bleed | Painful Urination | Prostate Problem |
| Cataracts | Dry Mouth | Urgency | Loss Bowel Control |
| Droopy Eyelids | Change in Taste | Blood in Urine | Heartburn/Nausea |

Are there any other health concerns you would like to discuss with the doctor? _____

## INSURANCE INFORMATION

Insurance company name (of your vehicle)_____ Phone _____

Insured's Name_____ Phone_____

Address_____ City_____ State_____ Zip_____

Adjuster_____ Claim #_____ Policy #_____

Have you contacted the insurance company? Y N Date_____ Who did you speak with?_____

Have you been contacted by the insurance company? Y N Date_____ Who did you speak with?_____

## OTHER VEHICLE INSURANCE INFORMATION

Insurance company's name_____ Phone_____

Insured's name_____ Phone_____

Driver's name_____ Phone_____

Address_____ City_____ State_____ Zip_____

Adjuster_____ Claim #_____ Policy #_____

Have you contacted the insurance company? Y N Date_____ Who did you speak with?_____

Have you been contacted by the insurance company? Y N Date_____ Who did you speak with?_____

## GROUP HEALTH INSURANCE INFORMATION

Company's name_____ Phone_____

Insured's name_____ Phone_____

Address_____ City_____ State_____ Zip_____

If applicable: Group #_____ Policy #_____ Plan #_____

## ATTORNEY INFORMATION

Attorney's name_____ Phone_____

Address_____ City_____ State_____ Zip_____

## ASSIGNMENT OF BENEFITS

I authorize payment of the benefits relating to this claim to be paid directly to:

**Silver Health Centers**

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due payable.

Patient Signature_____ Date_____