

Automobile Accident Intake Form

Please print

Patient Name: _____ H phone: _____ C phone: _____

Address/City/State/Zip: _____ DOB _____

Name of Insurance Co. _____ Claim Number: _____ DOA: _____

Address of Ins. _____ Contact Name: _____

Contact Phone: _____ Name of Lawyer _____

Address/Contact info for Lawyer _____

Please describe the accident in your own words: _____

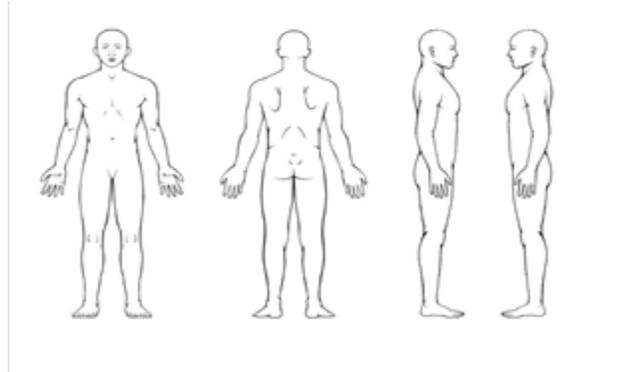
Your position in the vehicle: _____ Impact site on the vehicle: _____

If you were the driver were both hands on the steering wheel? Y or N if No, please describe where hands were _____

Were you X-rayed? Y or N Results of the X-rays _____

Did you have an MRI? Y or N Results of the MRI _____

Please circle areas of discomfort



Indicate pain level from 1 (low) to 10 (high) on the line provided.

Head	_____	Hips/Glutes	_____
Neck	_____	Legs	_____
Shoulders	_____	Knees	_____
Arms	_____	Ankle/Feet	_____
Back	_____		

Have you had any other tests or treatments? Y or N

Please explain include name (s) of treating Dr. (s)

List any medications you are taking: _____

Please indicate any condition you have or had recently

- | | |
|---------------------|-------------------------|
| Arthritis | Cancer |
| Headaches/Migraines | Joint Replacement (s) |
| Tendonitis | Stroke |
| Fibromyalgia | Heart Attack |
| Varicose veins | Sprains/Strains |
| Blood clots | High/low blood pressure |
| Diabetes | Clench/grind teeth/TMJ |
| Numbness | Circulation problems |

Patients Signature: _____

Date: _____

I understand that the massage given to me by Cindy Hebert is for the purpose of stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons stated here.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

Client signature _____ Date _____