Divine Lotus Massage

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Auto Accident Intake Form

Name:_____Date: _____

Referred by: _____

Address: _____

Phone:_____ Birthday: _____

Occupation:_____ E-mail: _____

Emergency Contact:_____ Phone:_____

Have you received massage therapy before?_____ If so what type?_____

Would you like to receive our monthly e- newsletter with special offers? Yes ___ No___

Employment

At time of accident, where did you work? _____ Unemployed _____

Where do you currently work? _____ Unemployed _____

If unemployed, is it due to injuries from the accident? Yes ___ No ___

What activities does your work require ? _____

Insurance

Insurance Company : _____ Policy # :_____

Insurance Contact Name : _____ Claim #: _____

Insurance Company Address : _____

Insurance Phone #:_____ Fax # :_____

Accident Details

Date of Injury: _____

You were: driver___ front passenger ___ rear passenger___ pedestrian ___bicyclist ___ other _____

Your vehicle (yr./make/model)_____

Your estimated speed at time of accident:_____ Were you: stopped ___ slowing ___ accelerating ___

Location/street _____

Direction of travel: N ___ E ___ S ___ W ___

Impact came from: Front ___ Rear ___ Left ___ Right ___ Other_____

Other vehicle (yr./make/model)_____

Time of day_____

Road conditions: Dry___ Damp ___ Wet ___ Icy ___ Snow ___ Other_____

During the accident :

Body position at impact:

Head: Forward___ Right ___ Left___ Up___ Down___ Unsure _____

Head Rest position: Up ___ Down ___ Unsure ___

Body: Forward ___Right ___Left ___Up ___ Down ___ Unsure ___

Lap belt: On ___ Off ___ Shoulder Harness: On ___ Off ___

Aware of impending crash? Yes ___ No ___ Was seat broken by impact? Yes ___ No ___ Unsure ___

Was your vehicle equipped with an airbag? Yes ___ No ___ If yes, did it inflate? Yes ___No ___

Were you struck by the airbag? Yes___ No___ If yes, where were you struck? _____

Did you strike any parts of the vehicle? Yes___ No ___ If yes, please describe_____

_____

Did your vehicle strike any objects after initial impact? Yes___ No___ If yes, please describe_____

_____

Was your vehicle pushed in any direction by the impact? Yes___ No ___ If yes, please describe_____

_____

Were you wearing a hat or glasses before impact? Yes___ No ___

If yes, were they still on after the impact? Yes ___ No ___

Did the accident render you unconscious? Yes ___ No ___ If yes, for how long?_____

After the accident:

Please describe how you felt immediately after the accident: _____

_____

_____

Were you seen by a doctor or did you go to a hospital after the accident? Yes ___ No ___

When did you go? Just after the accident ___ The next day ___ Days later ___ How many? ___

How did you get there? Ambulance ___Private transportation ___ Other : _____

Name of hospital and/or attending doctor: _____

Were X-rays taken? Yes ___ No___

Was medication prescribed? Yes ___No ___

Have you been able to work since the injury? Yes ___ No ___

Are your work activities restricted as a result of your injuries? Yes___ No ___

If yes, please describe _____

_____

Were the police on the scene? Yes ___ No ___ Was an accident report filed? Yes ___ No ___

Estimated property damage to your vehicle : $_____ None ___ Mild ___ Moderate ___ Major ___

Estimated property damage to other vehicle : $_____ None ___ Mild ___ Moderate ___ Major ___

Other information about the accident you'd like to share _____

_____

_____

Please indicate all of the symptoms which you feel are a result of this accident.

____Neck pain	____ Chest pain	____Memory loss
____Neck stiffness	____Shortness of breath	____Difficulty sleeping
____Jaw problems	____Shoulder pain	____Irritability
____Headache	____Mid-back pain	____Disorientation/Confusion
____Visual disturbances	____ Low back pain	____Nausea
____Auditory disturbances	____Leg pain	____Fatigue
____Numb feet/toes	____Tingling in extremities	____Dizziness/Fainting
____Numb hands/fingers	___Difficulty swallowing	____Loss of sense of smell

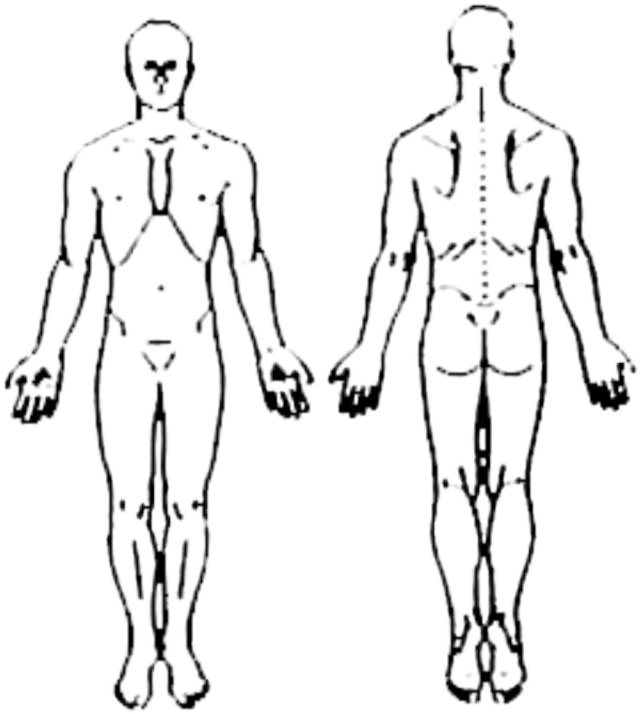
How long after accident did symptoms begin? _____

How frequent are the symptoms? _____

Please rate the severity on a scale from 1-10 (1 = slight discomfort and 10 = extreme pain):_____

_____

Mark all areas of current symptoms below:



To help evaluate the effect that your employment duties will have on your recovery, please indicate :

How many hours are in your normal work day?_____

Your daily job duties and any activities which you are occasionally asked to perform:

Daily: Standing ____ Driving ____ Operating equipment ____ Working with arms over head ____ Walking____

Lifting___ Sitting ____ Other _____

Occasional: Standing ____ Driving ____ Operating equipment ____ Working with arms over head ____

Walking ____ Lifting ____ Sitting ____Other _____

What positions can you work in with minimal physical effort & for how long?_____

_____

Informed Consent and Business Agreement

Full payment is expected at the time of service. A cancellation must be made 24 hours in advance to avoid charges. You are responsible for half the cost of an appointment canceled within 24 hours and full price of an appointment missed without cancellation. Payments must be made before receiving further treatment. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangement may be made to omit payment to await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to 6 months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize my provider, _____, to release my medical records relating to claim for benefits submitted.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I hereby give my consent to receive therapeutic massage.

Signature:_____Date:_____