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Purpose of Your Consult/Visit

Was injury/pain a result of an accident?: Yes_____ No_____

If yes: Job Related: ____Auto:____ Other:_____

What is the condition for which you are seeking medical attention? _____

_____

Site of injury (which body part)_____Side: Right____ Left____

Date of injury or onset: _____/_____/_____ Having Pain Since: _____/_____/_____

Attorney Information (if applicable):

Name:_____ Phone: ( ) _____-_____ Fax:( ) _____-_____

Describe the events of the injury/accident/pain:_____

_____

_____

Have you previously been treated for this or a similar condition? If yes, what was the treatment?

_____

_____

What were the results of the treatment? : _____

_____

List any previous major injuries/surgeries:_____

_____

_____

Have you had any diagnostic test related to condition (i.e. X-ray, MRI, CT, EMG)? If yes, please list.

No ( ) Yes ( )_____

(Please give any reports/results of testing to receptionist)

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers, I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Signature:_____ Date:_____