Molalla Spine & Sport

317 N. Molalla Avenue Molalla, OR 97038 – (503) 829-6176

Personal Injury Intake

Name:_____ Preferred Name:_____ Date:_____
Address:_____City:_____ State:_____ Zip:_____
Home Ph:_____ Email:_____
Male/Female Age:_____ Date of Birth:_____ Martial Status: M, S, D, W
Cell Phone:_____ Would you like to receive text reminders for appts? Y N
Serv Prov (Circle One): At&t – Boost – Cricket - Merto PCS – Nextel – Sprint - T-Mobile - US Cellular – Verizon - Virgin

Employer:_____
Work Phone:_____ Occupation:_____

Insurance Information

Auto Insurance Co:_____ Policy #:_____
Agents Name:_____ Agents Ph:_____
Name on Policy (if other than self):_____ Accident Claim #:_____
Claim Adjuster's Name:_____ Adjustors Ph:_____
Attorney's Name:_____ Attorney's Ph:_____
How did you hear about our office?_____

Medical History Please check all that apply to you: None Apply ☐

No	Yes	Condition	No	Yes	Condition
☐	☐	Recent Trauma	☐	☐	Birth Control Pills
☐	☐	Recent Fever/Infection	☐	☐	Pregnancy, # of Births___
☐	☐	Sleep Apnea/CPAP	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Diabetes	☐	☐	Urinary Tract Infection
☐	☐	High Blood Pressure	☐	☐	Frequent Urination
☐	☐	Heart Disease	☐	☐	Prostate Problems
☐	☐	Stroke (Date) _____	☐	☐	Visual Disturbances
☐	☐	Aortic Aneurysm	☐	☐	Dizziness/Fainting
☐	☐	Epilepsy/Seizures	☐	☐	Corticosteroid Use
☐	☐	Arthritis	☐	☐	History of Alcohol Use
☐	☐	Osteoporosis	☐	☐	History of Tobacco Use
☐	☐	Cancer/Tumor	☐	☐	History of Neck pain
☐	☐	HIV/AIDS	☐	☐	History of Mid/Low Back Pain

☐ ☐ Surgeries (List) _____
☐ ☐ Medication (List) _____
☐ ☐ X-Rays, MRI, CT Scan (List)_____

Family History: ☐Cancer ☐Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete to the best of my knowledge. I here by authorize this office and its Doctors to administer care to me as they deem necessary. I assign directly to Molalla Spine & Sport all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature _____ Date_____

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Patient Symptom Form – Initial

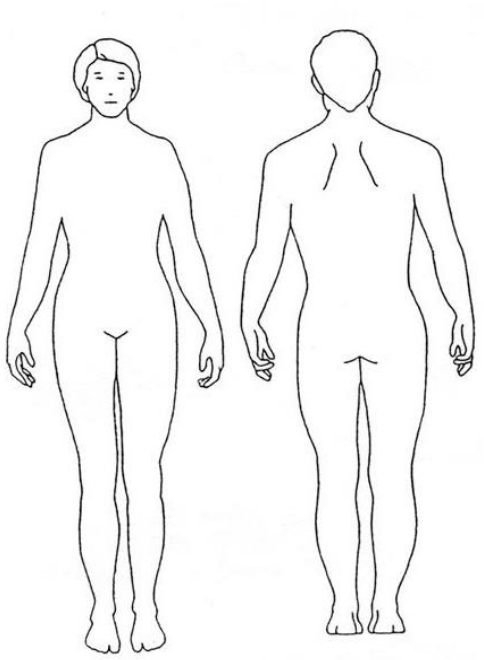
Name_____ **Date**_____

Complaint	Area #1	Area #2	Area #3
How are you feeling today? 0 = no pain thru 10 = much pain			
Does the pain travel anywhere? Where?			
Date pain began?			
How did the pain begin?			
How often does it hurt?			
What makes the pain worse?			
What makes the pain less?			
What can't you do that you did before the pain started?			
Have you tried anything at home to relieve the pain?			
Have you seen any other Doctors for it? Who? When?			
What did Doctors Advise?			
Have you had this pain before? When?			

Pain Drawing

Please indicate the location of pain and the symbol that best describes the discomfort you are feeling.

Type of Pain	Symbol
Sharp / Stabbing	+++++++
Dull / Achy	VVVVV
Pins / Needles	OOOOO
Numbness	/ / / / /



Signature_____