



First Time Visit Form Auto Accident - Personal Injury Protection (PIP)

Date: ____/____/____/
First Name: _____ Middle Initial: ____ Last Name: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____

Insurance Information

Who was at fault?

I was

If you are eligible for PIP with your insurance company you will be required to pay for your sessions until we receive confirmation of approval from your claim representative.

The other driver

If you are in the process of settlement with the other driver's insurance company you will be required to pay for your sessions and be reimbursed directly by the other driver's insurance company.

If You Were At Fault And Covered By PIP:

Name Of Your Insurance Company: _____ Claim No: _____
Address: _____ City: _____ State: ____ Zip Code: _____
Name Of Your Claims Representative: _____ Telephone: (____) _____

Name of Your Physician: _____ Telephone: (____) _____
Address: _____ City: _____ State: ____ Zip Code: _____

Confidential Information

Date of Birth: ____/____/____ Emergency Contact: _____
Telephone: (____) _____ Relationship: _____

Is this your first professional massage? Yes No

Date of Accident: ____/____/____

At The Time Of The Accident I Was: Driving A Passenger In The Front Seat A Passenger In The Back Seat

What side of the vehicle was hit in the accident? Front Back Left Side Right Side

If a passenger in the vehicle, where were you sitting? Front Back Right Back Left

How did your injury occur?

What conditions are you currently experiencing?

BACK

- Pain Middle Lower
- Stiffness Middle Lower
- Muscle spasms Middle Lower
- Pain between shoulder blades
- Pain from front to back
- Low back weakness
- Pinched nerve in low back

HANDS AND ARMS (Right, Left, Both)

- Pain in upper arm R L Both
- Pain in elbow R L Both
- Pain in forearm R L Both
- Pain in hand R L Both
- Pain in fingers R L Both
- Pins & needles in arm R L Both
- Pins & needles in fingers R L Both
- Numbness in arm R L Both
- Numbness in fingers R L Both
- Weakness of arm R L Both
- Weakness of hand R L Both
- Cold hands

NECK

- General pain
- Stiffness
- Weakness
- Pinched Nerve
- Neck feels out of place
- Muscle spasms
- Grinding/popping sounds

HIPS, LEGS & FEET (Right, Left, Both)

- Pain in buttocks R L Both
- Pain in hip joint R L Both
- Pain down leg R L Both
- Pain in knee R L Both
- Pain in ankle R L Both
- Pain in foot R L Both
- Weakness of leg R L Both
- Weakness of knee R L Both
- Leg cramps R L Both

Other Symptoms

Is the pain constant or does it come and go? Comes and goes Constant

Activities that are painful to perform: Sitting Walking Bending Lying Down Other

Describe the pain: Dull Sharp Achy Burning Throbbing Numb Tingling
 Other

At the moment the pain is: I have no pain Very Mild Moderate Fairly Severe
 Very Severe Unbearable

I am experiencing headaches: Rarely Most Of The Time

Describe what activities cause the pain and/or make it worse:

Does your condition interfere with your normal daily function? Yes No If yes, explain:

Please ✓ any of the following conditions that you are currently experiencing:

Arthritis Bursitis Carpal Tunnel Cramps Fibromyalgia Plantar Fasciitis Sciatica
 Tendonitis TMJ

Are you experiencing any of the following? Hernia Recent Bone Fracture Tumor

PLEASE READ AND SIGN

I _____ (please print) acknowledge that the above information is complete and accurate to the best of my knowledge. I agree to the release of information, if necessary, for medical and/or insurance purposes.

Signature: _____

Name: _____ Date: _____

Identify current symptomatic areas in your body by using the appropriate symbol for the condition and/or conditions you are currently experiencing.

- Circle any areas that are painful
- Place an X over areas where you are experiencing any stiffness**
- Draw squiggly lines in areas where you are experiencing tingling and/or numbness
- Note any scars, bruising or open wounds

Additional Comments:

