

CONFIDENTIAL INTAKE FORM

Date: _____

Full Name: _____

Address: _____
(street) (city) (state) (zip)

Mobile Phone #: _____ Home Phone #: _____

E-mail address: _____ Driver's License Number: _____

I would like to sign up to receive *BURMAN Law* **emails and newsletters: yes** _____ **no** _____

Have you seen our website on the internet or mobile internet? _____

Brief Work History:

How did you come to see us? _____

PRIOR MEDICAL HISTORY

Please Circle each appropriate letter next to each item based on the following:

Y= a condition you have now N= never had P= a condition you have had in past
If you had the condition in the past and have the condition now, then circle Y and P.

	Y	P	N	Physician		Y	P	N	Physician
Neck Pain					Right/Left Arm Pain/ Tingling				
Mid Back Pain					Right/Left Leg Pain/Tingling				
Back Pain					Right/Left Foot Pain/Tingling				
Lower Back Pain					Right/Left Hand Pain/Tingling				
Extremity Pain					Fingers/Toes Pain/Tingling				
Chest Pain					High Blood Pressure				
Muscle Spasms					Night Sweats				
Dizziness					Head Injury				
Vision Disturbance					Impaired Vision				
Restricted Motion					Corrected Vision				
Radiating pain					Impaired Hearing				
Ear Ringing					Edema				
Depression/Anxiety					Shortness of Breath				
Headaches					Muscle Weakness				
Prosthetic Replacement					Ligament or Tendon repair				
Joint Pain/Stiffness					Meniscus Tear				
Arthritis					Broken Bones				
Difficulty Sleeping					Deep Leg Pain				
Drug/Alcohol Abuse					Numbness/Tingling				

Prior Hospitalizations/Surgeries	Date	Physician/Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been in a prior accident? _____ When? _____

Details of prior accident: _____

Signature