VALLEY
MRI & RADIOLOGY, INC.

INTAKE FORM

Patient Name:	DOB:

Additional Reports To: _____

Reason for today's visit/symptoms: _____

_____

Is your visit due to a job related injury or automobile accident? ☐ YES ☐ NO

Date of Injury: _____ Check all that apply:

AUTO
- ☐ Driver
- ☐ Passenger
- ☐ Car
- ☐ Truck
- ☐ Van
- ☐ Motorcycle
- ☐ OTHER

_____

WORK

Type of work:

_____

ACTIVITY
- ☐ Running
- ☐ Walking
- ☐ Soccer
- ☐ Basketball
- ☐ Baseball
- ☐ Football
- ☐ Bicycling

OTHER

_____

WHERE
- ☐ Inside
- ☐ Outside
- ☐ Street
- ☐ Freeway
- ☐ House
- ☐ Apt
- ☐ MobileHome
- ☐ School
- ☐ Kitchen
- ☐ LivRm
- ☐ Bedrm
- ☐ Bathrm
- ☐ Hallway
- ☐ Garage
- ☐ Warehouse
- ☐ OTHER

_____

HOW: _____

_____

WorkComp/Auto Insurance:	
Claim #:	Phone:
Employer: (At time of injury):	
Current Employer:	

Which insurance are we billing for this exam?

Primary: _____

Secondary: _____

Other: _____

Diabetic ☐ YES ☐ NO Heart Disease ☐ YES ☐ NO

Type of diabetes: _____ HEIGHT: _____ WEIGHT: _____

Kidney/liver diseases ☐ YES ☐ NO High Blood Pressure ☐ YES ☐ NO

Any other medical conditions: _____

Medications: _____

_____

Signature Date

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