

AUTOMOBILE ACCIDENT INTAKE FORMS

Patient's Name: _____ Today's Date: _____
 Date of Accident: _____
 Date of Birth: _____

Address: _____ City: _____ State: _____
 Zip: _____

Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____

Social Security #: _____ Age: _____ Male Female
 Marital Status: Married Single Divorced Separated Other _____

Name of Spouse or Nearest Relative: _____ Phone: _____
 Your Occupation _____ Your Employer: _____

Referred to this Office by: Friend/Family Member - Name? _____
 Yellow Pages Mail Clinic Location Other _____

Payment for Services will be by: Cash Check Credit Card Health Insurance
 Automobile Insurance Worker's Compensation

Your PCP's name and number: _____
 Name of Insurance Co.: _____ Insured's Name: _____

Insured's ID #: _____ Insured's DOB: _____
 Are you covered by more than one insurance company? Yes No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F	S	M	F	S	M	F	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	polio
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	serious injury
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	venereal disease

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of Last Physical Exam _____

SURGICAL HISTORY:

1. _____ Date: _____
 2. _____ Date: _____
 3. _____ Date: _____

Have you ever had a metal implant? Yes No

ACCIDENT HISTORY: Job Auto Other 1. _____ Date: _____
 Job Auto Other 2. _____ Date: _____
 Job Auto Other 3. _____ Date: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms(1-10, with 1least serious)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ____MONTH(S) ____YEAR(S)

SYMPTOMS/COMPLAINTS: COME & GO ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: NO YES

WHEN?_____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND?_____

ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND?_____

ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE** YOUR CONDITION:

- BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
- LIFTING SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE** YOUR CONDITION:

- BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:

- blurred vision buzzing in ears cold feet cold hands cold sweats concentration loss /confusion
- constipation depression /weeping spells diarrhea dizziness face flushed fainting fatigue fever head seems too heavy headaches insomnia light bothers eyes loss of balance loss of smell loss of taste low resistance to colds muscle jerking numbness in fingers numbness in toes pins and needles in arms pins and needles in legs ringing in ears shortness of breath stiff neck stomach upset

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon Bus
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Mid-size Light
 Heavy Other _____

Your position in the vehicle:

- Driver
 Passenger ----- Location----- Left Middle Right
 Other _____ Front Passenger Rear Passenger Third Seat (rear)

Speed of your vehicle:

- Stopped Moving Moderately
 Parked Moving Fast
 Slowing Moving at apprx ____ MPH
 Moving Slowly

Why Vehicle was slowed or stopped:

- Traffic Signal Parking
 Pedestrian Traffic
 Stop Sign Busy Intersection

Collision Type:

- Driver Side Impact Head On Collision
 Passenger Side Impact Rear Impact
 Front Impact Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:

- Car Pickup
 Van Truck
 Station Wagon
 Other _____

Vehicle size:

- Subcompact Full-size
 Compact Mini
 Bus Mid-size Light
 Heavy Other _____

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:

- Full daylight
 Dawn
 Dusk
 Night

Road Conditions:

- Dry
 Damp
 Wet
 Snow covered
 Ice covered
 Patchy Ice/Snow

Visibility:

- Excellent
 Good
 Fair
 Poor

Visibility compromised by:

- Brightness
 Darkness
 Rain
 Snow
 Fog
 Traffic

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE ACCIDENT:

Were you...

- Totally unaware that the accident was impending
 Aware that the accident was impending
 Aware that the accident was impending and braced for it

Restraints: (check all that apply)

- Seat belt
 Shoulder harness
 No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? Yes No Knocked off by impact

Was the air bag deployed?

- Car not equipped with air bag
 Air bag deployed
 Air bag not deployed

What position was YOUR headrest in?

- High position
 Middle position
 Low position

Position of YOUR head at time of impact?

- Facing straight ahead
- Tilted forward
- Rotated to the left
- Rotated to the right

Was your head thrown...?

- Backward and then forward
- Forward then backward
- To the left To the left then the right
- To the right To the right, then the left

Position of Your body at time of impact?

- Straight
- Tilted forward
- Rotated to the left
- Rotated to the right

Was your body thrown...?

- Backward and then forward
- Forward then backward
- To the left To the left then the right
- To the right To the right, then the left
- Across the vehicle
- Outside the vehicle Under the vehicle

Damage to vehicle YOU were in:

- Incurred minimal damage
- Incurred moderate damage
- Incurred severe damage
- Was totalled
- Not known

Citations:

- None issued
- Yourself
- Driver of vehicle patient was a passenger of
- Driver of other vehicle
- Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Left Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Right Arm

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Torso

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Left Leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

Right Leg

- Steering wheel
- Dashboard
- Windshield
- Armrest
- Headrest
- Rear view mirror
- Left door
- Right door
- Left window
- Right window
- Console
- Gear shift
- Front seat
- Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

- Yes
- No

Immediately following the accident, did you feel...?

- Dizzy
- Dazed
- Disoriented
- Weak
- Nervous
- Nauseated

Were you able to walk unaided?

- Yes
- No

Where did you go...?

- Drove home
- Was driven home
- Drove to hospital
- Was driven to hospital
- Taken to hospital via ambulance
- Drove to work
- Was driven to work
- Drove to school
- Was driven to school

Next day discomfort...?

- increased
- decreased
- same

Did your major complaints exist before the accident?

- Yes
- No

In what areas did you IMMEDIATELY feel pain?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper back | Elbow | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Knee | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Mid back | Wrist | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Calf | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ribs | Hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest | Fingers | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Foot | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Abdomen | Buttock | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Toes | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

In what areas did you experience lacerations (cuts)?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

At the hospital, what areas were x-rayed?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
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| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

Where did you experience pain on the day FOLLOWING the accident?

- | | | | | | | |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head | Shoulder | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Neck | Arm | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Thigh | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <input type="checkbox"/> Low Back | <input type="checkbox"/> Pelvis | | | | | |

Patient's Signature: _____