

# 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 |
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| <input type="checkbox"/> Ribs       | Hand                            | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Ankle | <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?**

- |                                     |                                 |                               |                                |       |                               |                                |
|-------------------------------------|---------------------------------|-------------------------------|--------------------------------|-------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | Shoulder                        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | Hip   | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
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| <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 |                               |                                |       |                               |                                |

**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 |
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| <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 |                               |                                |       |                               |                                |

Patient's Signature: \_\_\_\_\_