

Automobile Accident Intake Form

Confidential Data



Patient Name: _____ DOB: (m/d/y) _____ Age: _____ Date: _____

Date of Accident: _____ Time: _____ am / pm Claim Number: _____

Please describe the accident in your own words: _____

The following questions pertain to YOU and the vehicle you were in:

Make and Model: _____ Year: _____

Vehicle type:

Car Van Pickup Sports Utility Vehicle Station Wagon Commercial Truck Other _____

Vehicle size:

Subcompact Compact Mid-size Large Car Small Pick-up Large Pick-up Small SUV Large SUV Other _____

Your position in the vehicle:

Driver Passenger: If passenger, were you: Front Passenger Rear Passenger Third Row Passenger Other _____
Where in the row? Drivers Side Middle Passenger Side

Speed of your vehicle:

Stopped Parked Slowing Accelerating Moving at approximately _____ miles per hour Other _____
If stopped or slowing, reason: Traffic Signal Stop Sign Pedestrian Parking Traffic

Collision type(s):

Front Impact Rear Impact Side Impact: Driver Side:... Front Side Middle Rear Side Other _____
 Passenger Side:... Front Side Middle Rear Side

The following questions pertain to the OTHER vehicle(s) involved:

Make and Model: _____ Year: _____

Vehicle type:

Car Van Pickup Sports Utility Vehicle Station Wagon Commercial Truck Other _____

Vehicle size:

Subcompact Compact Mid-size Large Car Small Pick-up Large Pick-up Small SUV Large SUV Other _____

Speed of the other vehicle:

Stopped Parked Slowing Accelerating Moving at approximately _____ miles per hour Other _____
If stopped or slowing, reason: Traffic Signal Stop Sign Pedestrian Parking Traffic

Collision type(s):

Front Impact Rear Impact Side Impact: Driver Side:... Front Side Middle Rear Side Other _____
 Passenger Side:... Front Side Middle Rear Side

Road conditions at the time of the accident:

Road/Street Name(s): _____ City/State: _____

Time of day:

Full Daylight Dawn Dusk Night

Road conditions:

Dry Damp Wet Snow Covered Ice Covered Patchy Ice/Snow Other _____

Visibility compromised?

No Brightness Darkness Rain Snow Fog Other _____

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Patient Name: _____ Date: _____ Claim Number: _____

The following questions pertain to the moment of IMPACT of the accident:

At the moment of impact, you were..:

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

If you were the driver of the vehicle, was your foot on the brake pedal?

- Yes No Knocked off by impact

Were both hands on the steering wheel?

- Yes No: If no, which hand was on the steering wheel? Left Right

Please describe the position of your hand(s) on the wheel: _____

Were you wearing a seatbelt?

- Yes No If yes, what type? Shoulder Lap

Was your vehicle equipped with air bags?

- Yes No If yes, was it/were they deployed? Yes No

Was your seat equipped with a headrest?

- Yes No If yes, what position was the headrest in: Low (below head) Middle (even with head) High (top of head)

Position of your HEAD at the time of impact?

- Facing straight ahead Tilted downward Tilted upward Turned to the left Turned to the right
Was your head jolted? Yes No
If yes, in which direction? Backward then forward Forward then backward To the left To the right Left then right Right then left

Position of your BODY at the time of impact?

- Facing straight ahead Tilted downward Tilted upward Turned to the left Turned to the right
Was your body jolted? Yes No
If yes, in which direction? Backward then forward Forward then backward To the left To the right Left then right Right then left

Miscellaneous Details:

Did the police come to the accident site?

- Yes No Citations issued? None Yourself Driver of the vehicle you were in Driver of other vehicle

Has a police report been filed?

- Yes No

Damage to the vehicle you were in:

- Minimal Moderate Severe Totaled Not known Amount: \$ _____

As a result of the force of the collision, which objects in the vehicle did your body strike:

Head:

- | | |
|---|--|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Headrest |
| <input type="checkbox"/> Air bag | <input type="checkbox"/> Front of seat |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Back of seat |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Left door |
| <input type="checkbox"/> Console | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Gear shift | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Armrest | |

Left Arm:

- | | |
|---|--|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Headrest |
| <input type="checkbox"/> Air bag | <input type="checkbox"/> Front of seat |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Back of seat |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Left door |
| <input type="checkbox"/> Console | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Gear shift | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Armrest | |

Right Arm:

- | | |
|---|--|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Headrest |
| <input type="checkbox"/> Air bag | <input type="checkbox"/> Front of seat |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Back of seat |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Left door |
| <input type="checkbox"/> Console | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Gear shift | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Armrest | |

Torso:

- | | |
|---|--|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Headrest |
| <input type="checkbox"/> Air bag | <input type="checkbox"/> Front of seat |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Back of seat |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Left door |
| <input type="checkbox"/> Console | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Gear shift | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Armrest | |

Left Leg:

- | | |
|---|--|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Headrest |
| <input type="checkbox"/> Air bag | <input type="checkbox"/> Front of seat |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Back of seat |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Left door |
| <input type="checkbox"/> Console | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Gear shift | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Armrest | |

Right Leg:

- | | |
|---|--|
| <input type="checkbox"/> Steering wheel | <input type="checkbox"/> Headrest |
| <input type="checkbox"/> Air bag | <input type="checkbox"/> Front of seat |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Back of seat |
| <input type="checkbox"/> Windshield | <input type="checkbox"/> Right door |
| <input type="checkbox"/> Rear view mirror | <input type="checkbox"/> Left door |
| <input type="checkbox"/> Console | <input type="checkbox"/> Right window |
| <input type="checkbox"/> Gear shift | <input type="checkbox"/> Left window |
| <input type="checkbox"/> Armrest | |

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Patient Name: _____ Date: _____ Claim Number: _____

The following questions pertain to the time period IMMEDIATELY FOLLOWING the accident:

Did you lose consciousness?

Yes No If yes, how long you were unconscious? _____

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 by ambulance
 Drove to work Was driven to work Drove to school Was driven to school Other: _____

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) or contusions (bruises)?

<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 symptoms on the day(s) 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
<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						

The day after the accident, your symptoms were: Better Worse Same

Did you go to the hospital at any time since the accident?

Yes No If yes, when? _____ Name of hospital? _____

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
<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						

Diagnoses given: _____

Treatment received: _____

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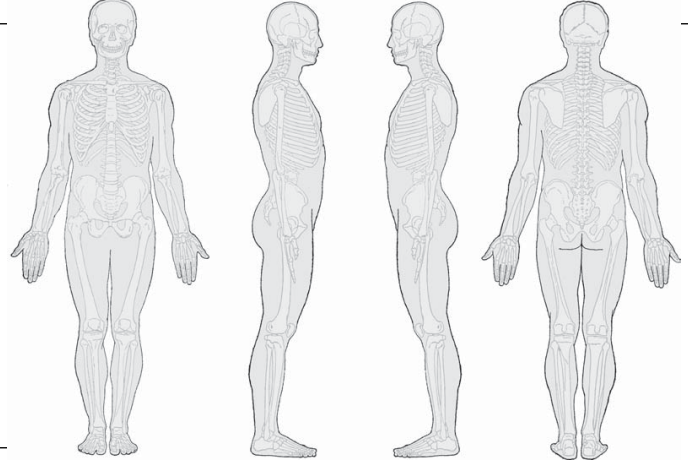
Patient Name: _____ Date: _____ Claim Number: _____

The following questions pertain to the symptoms/conditions you have experienced SINCE the accident:

Give a brief, detailed description of the problem(s) you are now experiencing: _____

Using the diagram and key, please draw where you are experiencing symptoms:

1. Achey, Dull, Sore
2. Stiffness, Tightness
3. Sharp Stabbing
4. Sharp Shooting
5. Numbness, Tingling
6. Burning
7. Throbbing
8. Swelling
9. Snapping, Popping, Grinding
10. Other: _____



When did the condition(s) start? _____

Please describe what happened: (if additional information to accident) _____

Your symptoms are: Constant - if constant, are they truly present 24hrs/day? Yes No
 Intermittent - if intermittent, how often do you feel them? _____ x/day How long do they last? _____
 - associated with any activities/positions/etc? _____

Compared to onset, are your symptoms: Better Worse Same

Do your symptoms prevent you from getting to sleep? Yes No Wake you at night? Yes No

Have you ever had the problem(s) before? Yes No If so, please explain: _____

Please name your conditions/areas: 1: _____ 2: _____ 3: _____

Please rate the severity of your pain/symptoms: (0=no pain : 10=unbearable)
 At Onset >>>

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

 Average >>>

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Percentage of time you experience symptoms: _____ % _____ % _____ %

What makes your condition(s) worse? (e.g. positions, activities, etc.) _____

What makes your condition(s) better? (e.g. positions, activities, heat/ice, medications, etc.) _____

Are your activities of daily living affected? (e.g. difficulty performing work duties, getting dressed, etc.) Yes No If so, please explain: _____

Please describe any other conditions/symptoms you feel are related to this complaint: _____

Have you ever been treated for this condition previously? Yes No If so, please complete below:

Date	Practitioner	Facility	Diagnosis	Treatment Provided

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Patient Name: _____ Date: _____ Claim Number: _____

The following questions pertain to your **MEDICAL HISTORY** and **GENERAL HEALTH**:

Please list any serious illnesses you have had: _____

Please complete the following table describing any hospitalizations or surgeries:

Date	Practitioner/Facility	Reason/Diagnosis	Treatment Provided

Please describe any major accidents/traumas/injuries you have had and the treatment received: _____

Please list any medications you are presently taking: (include vitamins)

Medication	Dose	Reason

Please list any allergies: _____

When was your last physical exam? _____

Any pertinent results? _____

Have you seen a chiropractor before? Yes No

If so, who? _____

What for? _____

Please describe any medical conditions that run in your immediate family: (e.g. heart disease, cancer, etc.; include siblings, parents, and grandparents)

Relative(s)	Conditions

Relative(s)	Conditions

Do you do any regular exercise? Yes No If so, please describe: (what, how much, how often) _____

Please describe your diet: _____

How often do you eat the following? (x/day or wk) _____ Fruits _____ Vegetables _____ Dairy _____ Meat _____ Sweets

How much water do you drink? _____ glasses/day

How much coffee? _____ cups/day

Do you drink alcohol? Yes No If so, how much? _____ Do you smoke? Yes No Packs/day: _____ How long? _____

How often do you have a bowel movement? _____ x/day or wk Recent Changes? Yes No Describe: _____

Any recent changes in bladder function? (freq, urgency, difficulty start/stop) Yes No Describe: _____

Women Only: Do you have a menstrual cycle? Yes No If so, when was your last cycle? _____

If not, please explain: _____

Are you presently on a contraceptive medication? Yes No If so, what? _____

Are you, or could you be pregnant? Yes No If so, estimated due date? _____

By signing below, I certify that the information in this document is full and complete to the best of my knowledge:

Patient Signature: _____ Date: _____

(parent/guardian if under 18)