Auto Accident Intake Form

PATIENT INFORMATION

Last/First NAME: _____ Date: _____

SS: _____ DOB: _____ Married/Single/Divorced/Widow Children: _____

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

Telephohe: HOME _____ CELL _____ WORK _____

Date of Accident _____ AM or PM Weather: Sunny/Rainy/Foggy/Windy/OTHER _____

Please describe the accident in your own words _____

_____

_____

_____

Were you the: ☐ Driver ☐ Front passenger ☐ Rear passenger ☐ Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have headrest? ☐ Yes ☐ No

If yes, what was the position of the headset?

☐ Low ☐ Mid-Position ☐ High

NOTE: _____

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain _____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No

If yes, explain _____

_____

Was impact from:

☐Front ☐Rear ☐Left ☐Right Other _____

At the time of impact were you:

☐Looking straight ahead ☐Looking to the right

☐Looking to the left ☐Looking down

☐Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐Surprised by impact ☐Braced by impact

NOTE: _____

OTHER VEHICLE

(if applicable)

Make and model of other vehicle _____

_____

Which direction was other vehicle headed?

_____

Speed other vehicle was traveling _____

_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom? _____

NOTE: _____

PATIENT INFORMATION

Were you unconscious immediately after the accident? □ Yes □ No If yes, for how long? _____
Please describe how you felt immediately after the accident? _____
_____

TREATMENT

Did you go to the Hospital? □ Yes □ No
Name of Hospital _____
When was your last visit to the Chiropractor? _____
Which operations have you had in your lifetime? _____
Which bones have you fractured or broken in your lifetime? _____
Treatment received _____
X-ray taken: □ Yes □ No _____ Prescription prescribed: □ Yes □ No _____
When did you go? □Immediately after accident □Next day □2 days or more after the accident
How did you get to the Hospital? □Ambulance □Private transportation (describe) _____

SYMPTOMS/INJURIES

Have you ever had neck or back pain before? □ Yes □ No Was there a trauma associated with that pain? □ Yes □ No
When was your last car accident? _____
When was your last (hospital/walk-in) visits due to trauma? _____
Have you ever had spinal x-rays, MRI, or CT scan for your areas of complaint? □ Yes □ No
Is there any pain associated with these activities since your recent accident/injury? □ Yes □ No

Self Care and Personal Hygiene
Eating: □ Yes □ No
Bathing: □ Yes □ No
Dressing: □ Yes □ No
Brushing Teeth: □ Yes □ No
Combing Hair: □ Yes □ No
Urinating: □ Yes □ No
Bowel Function: □ Yes □ No

Communication
Writing: □ Yes □ No
Typing: □ Yes □ No
Hearing: □ Yes □ No
Speaking: □ Yes □ No

Physical Activity
Standing: □ Yes □ No
Sitting: □ Yes □ No
Reclining: □ Yes □ No
Walking: □ Yes □ No
Climbing Stairs: □ Yes □ No

Sensory Function
Hearing: □ Yes □ No
Seeing: □ Yes □ No
Touching: □ Yes □ No
Tasting: □ Yes □ No
Smelling: □ Yes □ No

Non-Specialized Hand Activities
Grasping: □ Yes □ No
Lifting: □ Yes □ No
Altered Sensation in the Hands: □ Yes □ No

Travel
Driving: □ Yes □ No
Flying: □ Yes □ No
Riding: □ Yes □ No

Movement
Twisting: □ Yes □ No
Bending: □ Yes □ No
Reaching: □ Yes □ No
Getting up: □ Yes □ No

Sleep
Restful: □ Yes □ No

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change of health.

_____ _____
Signature or Patient Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or personal Representtive Relationship to Patient

VISUAL ANALOG SCALE & ASSOCIATED PAIN

Name_____ Date_____

Please mark on the 0 to 10 scale, your involvement with pain to the following locations and situations, from no involvement (0) to maximum involvement (10). Mark the scale with a vertical line.

1. Do you have headaches? If so how severe are they? Circle what you feel. (Sharp, Burning, Throbbing, Achy, Dull, Diffuse)
None at all 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Intolerable

2. How frequent are your headaches?
Infrequent 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 All the time

3. Do you have any pain in your neck? How severe is it? (Sharp,Shooting, Stiff, Sore, Achy, Dull, Diffuse)
No Pain 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Intolerable

4. How frequent is your neck pain?
Infrequent 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 All the time

5. Do you have radiating pain, numbness or tingling into your arms or hands? (Mark for right and left)
None Intolerable None Intolerable
Left 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Right 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10

6. Do you use pain killers? Yes_____ No_____ If so how much relief?
Complete relief 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 No relief

7. Do you have pain in your (please put circle) shoulders, elbows, wrists or fingers?
None Intolerable
Right 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Circle how you feel. (Sharp, Stiff, Sore, Achy, Dull, Diffuse)
Left 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Circle how you feel. (Sharp, Stiff, Sore, Achy, Dull, Diffuse)

8. Do you have any pain in your mid back? How severe is it? (Sharp, Stiff, Sore, Achy, Dull, Diffuse)
No Pain 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Intolerable

9. How frequent is your mid back pain?
Infrequent 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 All the time

10. Do you have any pain in your low back? How severe is it? (Sharp, Stiff, Sore, Achy, Dull, Diffuse)
No Pain 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Intolerable

11. How frequent is your low back pain?
Infrequent 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 All the time

12. Do you experience any radiating numbness, tingling, and/or pain into your legs?
No pain Severe pain No pain Severe pain
Right 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10 Left 0…..1…..2…..3…..4…..5…..6…..7…..8…..9…..10

13. Do you have any pain in your (hips), (knees), (ankles) or (feet)? (Please circle injured joint)
No pain Severe pain No pain Severe pain
Left 0…1...2…3...4...5....6....7....8....9...10 (Sharp, Stiff, Sore, Achy, Dull, Diffuse) Right 0…1...2…3...4...5....6....7....8....9...10 (Sharp, Stiff, Sore, Achy, Dull, Diffuse)

_____
Signature