MOTOR VEHICLE ACCIDENT INTAKE

Today's Date: _____

Patient Name: _____ Age: _____ Occupation: _____

Date of Accident: _____ Time of Accident: _____ ☐AM ☐PM

Please describe the accident in your own words:

_____

_____

_____

_____

_____

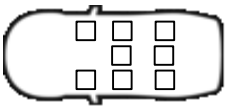
_____

_____

_____

_____

Where were you sitting?



OR: I was a
☐ pedestrian
☐ bicyclist
☐ motorcyclist

How many people, including you, were in your vehicle? _____

YOUR VEHICLE

Year _____ Make _____ Model _____

Does your vehicle have airbags? ☐ yes ☐ no

If yes, did they inflate? ☐ yes ☐ no

If yes, did they inflate properly?

☐ yes ☐ no ☐ unsure

Were you wearing a seatbelt? ☐ yes ☐ no

If yes, ☐ lap only ☐ shoulder only ☐ both

Did you sustain visible bruising from the seatbelt?

☐ yes ☐ no

If yes, was it from the: ☐ lap only ☐ shoulder only ☐ both

Is bruising still visible? ☐ yes ☐ no

Where is/was the bruising? _____

_____

_____

Did your seat have a headrest? ☐ yes ☐ no

If yes, is it moveable? ☐ yes ☐ no

What position was it in, in relationship to your head?

☐ low ☐ mid ☐ high ☐ unsure

Did your head strike the headrest? ☐ yes ☐ no

Where were your hands?

Left: ☐ steering wheel

☐ other _____

Right: ☐ steering wheel ☐ gear shift

☐ other _____

Where were your feet?

Left: ☐ brake ☐ clutch ☐ floor

☐ other _____

Right: ☐ gas ☐ brake ☐ floor

☐ other _____

What direction were you looking? (check all that apply)

☐ straight ahead ☐ to the left ☐ to the right

☐ down ☐ up ☐ in the rear-view mirror

☐ in the side-view mirror ☐ left ☐ right

☐ behind you to the ☐ left ☐ right

Were you:

☐ surprised by impact ☐ braced for impact

☐ surprised by impact but had time to brace

☐ unsure

NAME:_____ DOB:_____ DATE:_____

THE OTHER VEHICLE

Year _____ Make _____ Model _____

What direction was the other vehicle travelling?
☐ north ☐ south ☐ east ☐ west

Did the other vehicle's airbags inflate?
☐ yes ☐ no ☐ unsure

REPORTS

Did police come to the scene? ☐ yes ☐ no
Was a police report filed? ☐ yes ☐ no
Were you issued a citation? ☐ yes ☐ no
Was the other driver issued a citation?
☐ yes ☐ no ☐ unsure

THE ACCIDENT

Name of Road/Street: _____

Name of Closest Intersection: _____
Did the accident happen in the intersection?
☐ yes ☐ no
City: _____ State: _____
What direction were you travelling?
☐ north ☐ south ☐ east ☐ west
What were the driving conditions?
☐ wet ☐ dry ☐ icy ☐ foggy
☐ other _____
Were you stopped? ☐ yes ☐ no
If no, what was your approximate speed?_____

THE IMPACT

How was your vehicle hit? (check all that apply)
☐ squarely ☐ at an angle ☐ rear-ended ☐ head-on
☐ T-boned ☐ other _____

Did any part of your body (other than your head on the headrest) strike any part of the vehicle?
☐ yes ☐ no
If yes, please state what body part and where it struck in the vehicle: _____

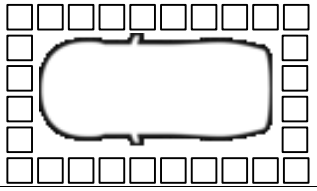
_____

Do you have an estimate of damage to your vehicle?
☐ yes ☐ no
If yes, please explain: _____

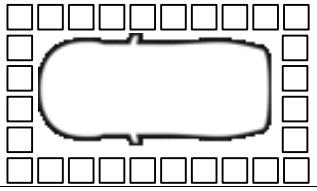
_____

THE DAMAGE

Please mark all of the impact areas on your vehicle:



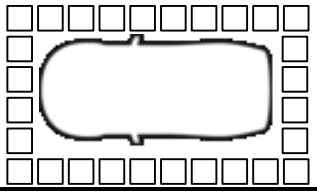
Please mark all of the impact areas on the other vehicle:



Did your vehicle impact anything else? ☐ yes ☐ no
If yes, what did it impact? _____

_____

Please mark all areas of the second impact:



AT THE SCENE

Did medical personnel (ambulance, fire) come to the scene? ☐ yes ☐ no
If yes, were you treated at the scene? ☐ yes ☐ no
If yes, what treatment did you receive? _____

_____

NAME:_____ DOB:_____ DATE:_____

HOSPITAL/EMERGENCY DEPARTMENT

Did you go to the Emergency Room? ☐ yes ☐ no If no, skip to next section
If yes, what was the name of the hospital? _____

What was the doctor's name (if known)? _____
Did you go by: ☐ ambulance ☐ someone drove me ☐ I drove myself
When did you go to the Emergency Room? ☐ Immediately after the accident ☐ the next day
☐ two or more days later ☐ _____ # of hours after the accident

Were x-rays taken? ☐ yes ☐ no
If yes, what x-rays were taken? (check all that apply): ☐ neck ☐ upper back ☐ mid back ☐ low back
Left: ☐ shoulder ☐ upper arm ☐ elbow ☐ forearm ☐ wrist ☐ hand ☐ fingers ☐ hip
☐ thigh ☐ knee ☐ calf ☐ ankle ☐ foot ☐ toes
Right: ☐ shoulder ☐ upper arm ☐ elbow ☐ forearm ☐ wrist ☐ hand ☐ fingers ☐ hip
☐ thigh ☐ knee ☐ calf ☐ ankle ☐ foot ☐ toes
☐ I had x-rays, but I am not sure what was x-rayed.
☐ Additional x-rays not marked above: _____
Do you know the results of your x-rays? ☐ yes ☐ no
If yes, please explain: _____

Were any additional tests performed? ☐ unsure ☐ yes ☐ no
If yes, do you know what tests were performed? ☐ yes ☐ no
If yes, please check all that apply: ☐ blood ☐ CAT/CT scan ☐ MRI ☐ other _____
Do you know the results of any of these tests? ☐ yes ☐ no
If yes, please explain: _____
Did you receive a diagnosis? ☐ yes ☐ no If yes, please explain: _____

Please explain any treatment given in the Emergency Room: _____
☐ I was not given any treatment.
Upon leaving, what treatment plan were you given? _____
☐ I was not given a treatment plan.
What prescriptions (and dosing), if any, were you given?_____
☐ I was not given any prescriptions.

AFTER THE ACCIDENT

Have you seen your primary care physician or any other doctor since the accident? ☐ yes ☐ no
If no, skip to next section
If yes, what was the name of the physician? _____
Was this doctor your primary care physician? ☐ yes ☐ no
What date(s) did you see this doctor? _____

Were x-rays taken? ☐ yes ☐ no
If yes, what x-rays were taken? (check all that apply): ☐ neck ☐ upper back ☐ mid back ☐ low back
Left: ☐ shoulder ☐ upper arm ☐ elbow ☐ forearm ☐ wrist ☐ hand ☐ fingers ☐ hip
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☐ thigh ☐ knee ☐ calf ☐ ankle ☐ foot ☐ toes
☐ I had x-rays, but I am not sure what was x-rayed.
☐ Additional x-rays not marked above: _____
Do you know the results of your x-rays? ☐ yes ☐ no
If yes, please explain: _____

Were any additional tests performed? ☐ unsure ☐ yes ☐ no
If yes, do you know what tests were performed? ☐ yes ☐ no
If yes, please check all that apply: ☐ blood ☐ CAT/CT scan ☐ MRI ☐ other _____
Do you know the results of any of these tests? ☐ yes ☐ no
If yes, please explain: _____
Did you receive a diagnosis? ☐ yes ☐ no If yes, please explain: _____

NAME:_____ DOB:_____ ATE:_____

AFTER THE ACCIDENT (con't)

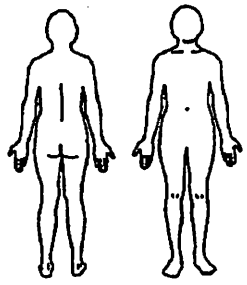
Were any additional tests performed? unsure yes no
If yes, do you know what tests were performed? yes no
If yes, please check all that apply: blood CAT/CT scan MRI other _____
Do you know the results of any of these tests? yes no
If yes, please explain: _____
Did you receive a diagnosis? yes no If yes, please explain: _____

Please explain any treatment given at the doctor's office : _____
I was not given any treatment.
Upon leaving, what treatment plan were you given? _____
I was not given a treatment plan.
What prescriptions (and dosing), if any, were you given? _____
I was not given any prescriptions.

Have you been able to work since this injury? Yes No How many work days have you missed? _____
Prior to the injury, were you able to work on an equal basis with others your age? Yes No
If no, what has changed? _____

Have you had any of the following symptoms since your injury? (*check all that apply*)

Arm/Shoulder pain	Feet/toe numbness	Neck pain
Back pain	Hand/finger numbness stiffness	Neck stiffness
Back stiffness	Headaches	Shortness of Breath
Chest pain	Irritability	Sleep difficulty
Dizziness	Jaw problems	Stomach upset
Ear buzzing	Leg pain	Tension
Ear ringing	Memory loss	Vision blurred
Fatigue	Nausea	



Mark an X on the picture where you continue to have pain, numbness, or tingling:

Is this condition getting progressively worse? yes no unknown

Movements that are painful: sitting standing walking bending lying down

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Type of pain (mark all that apply):

Sharp	Dull	Throbbing	Numbness
Aching	Shooting	Burning	Tingling
Cramps	Stiffness	Swelling	Other_____

How often do you get this pain? _____

Is the pain constant or does it come and go?

Does it interfere with your Work Sleep Daily routine Recreation?

Have you received any additional treatment other than what you listed above? yes no
If yes, please fill in the information: (use the back side if more space is needed)

Date (s)	Name of Practitioner	Type of Practitioner	Treatment
		MD ND LAc LMT PT DC DO other _____	
		MD ND Lac LMT PT DC DO other _____	

NAME:_____ DOB:_____ DATE:_____

Please explain any treatment given at the doctor's office : _____
☐ I was not given any treatment.
Upon leaving, what treatment plan were you given? _____
☐ I was not given a treatment plan.
What prescriptions (and dosing), if any, were you given?_____
☐ I was not given any prescriptions.

Have you received any additional treatment other than what you listed above? ☐ yes ☐ no
If yes, please fill in the information: (use the back side if more space is needed)

Date (s)	Name of Practitioner	Type of Practitioner	Treatment
		☐ MD ☐ ND ☐LAc ☐LMT ☐ PT ☐ DC ☐ DO ☐ other _____	
		☐ MD ☐ ND ☐Lac ☐LMT ☐ PT ☐ DC ☐ DO ☐ other _____	

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

_____ _____
Signature of patient (or parent/guardian or personal representative of patient) Date:
Relationship to patient: ☐ self ☐ parent ☐ guardian ☐ representative

Your insurance company:	Your Claim Number:	Your Agent's Name:
_____	_____	_____
		Agent's Phone: _____

For office use only: N _____ B _____