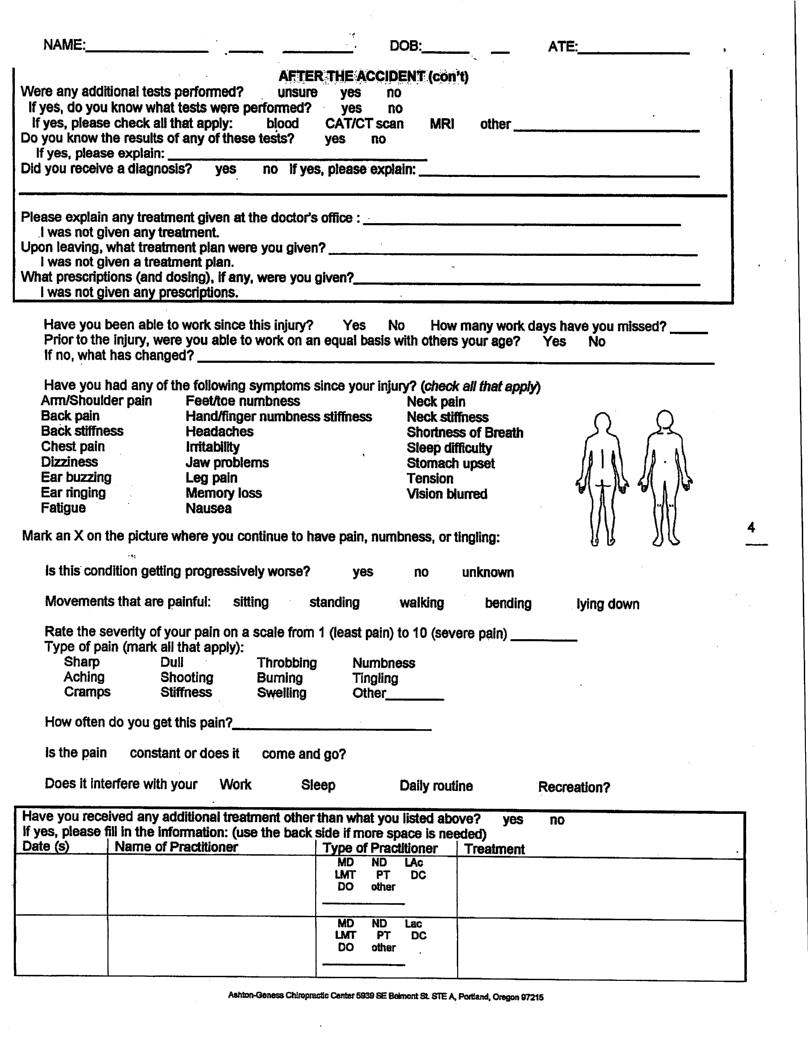
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| **MOTOR VEHICLE ACCIDENT INTAKE** | | | | | | | | | | |
|  | |  |  | | | | |  | Today’s Date: | |
| Patient Name: | | | | Age: | | Occupation: | | | | |
| Date of Accident: | Time of Accident: | | | |  | |  | | |  |

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| Please describe the accident in your own words: |  | Where were you sitting?          OR: I was a  How many people, including you, were in your vehicle? |

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| **YOUR VEHICLE** |  | **THE ACCIDENT** | | |
| Year       Make       Model |  | Name of Road/Street: | | |
| Does your vehicle have airbags?  If yes, did they inflate? d  If yes, did they inflate properly?  Were you wearing a seatbelt?  If yes,  lap only  shoulder only  both  Did you sustain visible bruising from the seatbelt?  If yes, was it from the:  Is bruising still visible?  Where is/was the bruising?  Did your seat have a headrest?  If yes, is it moveable?  What position was it in, *in relationship to your head*?  Did your head strike the headrest?  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 of Closest Intersection:  Did the accident happen in the intersection? | | |
|  | City: | | State: |
|  | What direction were you travelling?  What were the driving conditions?  wet  dry icy foggy other  Were you stopped?  yes  no  If no, what was your approximate speed? | | |
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|  | **REPORTS** | | |
|  | Did police come to the scene?  Was a police report filed?  Were you issued a citation?  Was the other driver issued a citation? | | |
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|  | **THE IMPACT** | | |
|  | How was your vehicle hit? (check all that apply)  squarely  at an angle  rear-ended  head-on T-boned  other | | |
|  |  | | |
|  | 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?  If yes, what did it impact? | | |
|  | Please mark all areas of the second impact: | | |
|  |  | | |
|  | Did any part of your body (other than your head on the headrest) strike any part of the vehicle?  If yes, please state what body part and where it struck in the vehicle: | | |
|  |  | Do you have an estimate of damage to your vehicle?  If yes, please explain: | | |
| **THE OTHER VEHICLE** |  |
| Year       Make       Model |  |
| What direction was the other vehicle travelling?  Did the other vehicle’s airbags inflate? |  |

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| Patient Name: | | | | DOB: | | Today’s Date: | | |
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| **MEDICAL INFORMATION** | | | | | | | | |
| **AT THE SCENE** | | |  | | **PAST MEDICAL HISTORY** | | | | |
| Did medical personnel (ambulance, fire) come to the scene?  If yes, were you treated at the scene?  If yes, what treatment did you receive? | | |  | | Have you been in any previous motor vehicle accidents?  If yes, please list the dates:  Did you fully recover from this (these) accident(s)?  If no, please explain: | | | | |
|  |  | |  | | Have you had any prior injury to any of the areas in which you now have pain?  If yes, please explain: | | | | |
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| **HOSPITAL/EMERGENCY DEPARTMENT** | | |  | | **AFTER THE ACCIDENT** | | | | |
| Did you go to the Emergency Room?  If no, skip to next section  If yes, what was the name of the hospital?  What was the doctor’s name?  Did you go by:  When did you go to the Emergency Room?  OR       # of hours after the accident | | |  | | Have you seen your primary care physician or any other doctor since the accident?  If no, skip to next section  If yes, what was the name of your doctor?  Was this doctor your primary care physician?  What date(s) did you see this doctor? | | | | |
| Were x-rays taken?  If yes, what x-rays were taken? (check all that apply):  neck  upper back  mid back  low back | | |  | | Were x-rays taken?  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 | | |  | | 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 | | |  | | 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?  If yes, please explain: | | |  | | 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?  If yes, please explain: | | | | |
| Were any additional tests performed?  If yes, do you know what tests were performed?  If yes, please check all that apply:  blood  CAT/CT scan  MRI  other  Do you know the results of any of these tests?  If yes, please explain: | | |  | | Were any additional tests performed?  If yes, do you know what tests were performed?  If yes, please check all that apply:  blood  CAT/CT scan  MRI  other  Do you know the results of any of these tests?  If yes, please explain: | | | | |
| Did you receive a diagnosis?  If yes, please explain: | | |  | | Did you receive a diagnosis?  If yes, please explain: | | | | |
| Please explain any treatment given in the Emergency Room:  I was not given any treatment. | | |  | | Please explain any treatment given in 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. | | |  | | 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. | | |  | | What prescriptions (and dosing), if any, were you given?  I was not given any prescriptions. | | | | |

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| Have you received any additional treatment other than what you listed above?  If yes, please fill in the information: | | | |
| Date (s) | Name of Practitioner | Type of Practitioner | Treatment |
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| 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) Relationship to patient:  By marking this box, I acknowledge that my printed name functions as my electronic signature | Date: |

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| Your insurance company: | Your Claim Number: | Your Agent’s Name:  Agent’s Phone: |

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| For office use only: N       B |