Devine Chiropractic and Rehab Center

Automobile Accident Patient Intake Form

Name_____ Today's Date_____ Date of Accident_____

Time Of Accident_____ am / pm Street/City/Location of Accident_____

Road Conditions at Time of Accident: ○Icy ○Rainy ○Wet ○Clear ○Dark ○Other_____

Visibility at the time of Accident: ○Poor ○Fair ○Good ○Other_____

What type of vehicle were you in? Year_____ Make_____ Model_____

Who owns the vehicle you were in?_____ How many people were in your vehicle?_____

Were you the: ○Driver ○Front Passenger ○Rear Passenger ○Pedestrian

The vehicle you were in was heading: ○North ○South ○East ○West How fast was your vehicle going?_____

Your vehicle was: ○Accelerating ○Slowing down ○Maintaining a constant speed ○Stopped

If you were stopped, was your foot on the brake? ○Yes ○No

Were there other vehicles involved? ○Yes ○ No What type of vehicle? Year_____Make_____Model_____

Direction the other vehicle was heading: ○North ○South ○East ○West How fast were they traveling?_____

The vehicle was: ○Accelerating ○Slowing down ○Maintaining a constant speed ○Stopped

Type of accident: ○Head-on Collision ○Broad-side Collision ○Front Impact ○Rear-ended car in front

○Rear-ended ○Non-Collision

Did your vehicle strike the others involved? ○Yes ○No Was your vehicle struck by others involved? ○Yes ○No

What was the damage done to the vehicle you were in? $_____

Were you aware of the impending accident? ○Yes ○No If yes, did you brace for impact? ○Yes ○No

Were you wearing: ○Shoulder Harness and Lap Belt ○Lap Belt Only ○No Seatbelt

Did any part of your body hit the inside of your vehicle? If Yes, please describe._____

_____

What was the position of your headrest at the time of impact? ○Top of headrest even with the bottom of your head
○Top of headrest even with the middle of your neck
○Top of headrest even with the top of your head
○My vehicle doesn't have headrests

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Was the trunk of your body facing forward at the time of impact? ○Yes ○No

Was your head facing forward? ○Yes ○No If No, which direction was your trunk and head turned and how much?

_____

Did you feel any popping, tearing, ripping, or unusual noise from your neck and back during impact? ○Yes ○No

Did the accident render you unconscious? ○Yes ○No If Yes, how long?_____

Did the police come to the scene of the accident? ○Yes ○No Were citations given? ○Yes ○No If Yes, to whom were the citations given?_____

Please describe the accident in your own words:_____

_____

_____

_____

_____

Were you able to get out of the vehicle and walk unaided? ○Yes ○No Were you able to move all of your body parts? ○Yes ○No If No, please describe:_____

_____

Please describe how you felt :

●Immediately after the accident:_____

●Later that day_____

●During the next few days_____

Did you seek medical attention? ○Yes ○No If Yes, how did you get there? ○Ambulance ○I drove ○Someone else drove me

First Doctor/Hospital/Clinic seen:_____ Were you examined? ○Yes ○No

Were x-rays taken? ○Yes ○No Date first seen:_____ Date last seen:_____

What kind of treatment did you receive?_____

What benefits did you receive from the treatment?_____

Second Doctor/Hospital/Clinic seen: :_____ Were you examined? ○Yes ○No

Were x-rays taken? ○Yes ○No Date first seen:_____ Date last seen:_____

What kind of treatment did you receive?_____

What benefits did you receive from the treatment?_____

What is your occupation?_____ Employer_____

Employer Phone_____ Address_____

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Automobile Accident Patient Intake Form Page 2

Have you missed time from work? ○Yes ○No ○Unable to work since accident

If Yes, please list the dates:

Full-time off work from _____/_____/_____ to _____/_____/_____

Part-time off work from _____/_____/_____ to _____/_____/_____

Light duty from _____/_____/_____ to _____/_____/_____

Check all symptoms apparent since the accident:

○Headache	○Neck pain/Stiffness	○Sleeping problems	○Nervousness
○Tension	○Anxiety	○Fatigue	○Depression
○Irritability	○Difficulty Concentrating	○Loss of Memory	○Dizziness
○Light sensitivity	○Restlessness	○Fever	○Ringing in ears
○Loss of balance	○Fainting	○Shortness of breath	○Chest pain
○Upset stomach	○Diarrhea/Constipation	○Pain in arms	○Pain in legs
○Mid-back pain	○Low-back pain	○Pain in shoulders	○Pain behind eyes
○Numbness in fingers/toes	○Cold hands/feet	○Loss of smell	○Loss of taste
○Facial pain	○Cold sweats	○Clicking/popping jaw	○Head seems heavy
○Other_____			

Briefly describe any past falls, injuries, accidents, operations, and the dates they occurred:_____

_____

_____

Prior to this have you ever had any symptoms similar to those you are experiencing now? ○Yes ○No

If Yes, please explain:_____

_____

Did you have any physical complaints before the accident? ○Yes ○No

If Yes, please describe and note any changes since the accident:_____

_____

Has a family member had the following: (check all that apply)

○Arthritis	○Blood Disorders	○Cancer	○Diabetes
○Epilepsy	○Tuberculosis	○Hypertension	○Gout
○Mental Illness	○Kidney Disease	○Heart Attack	○Spinal Disorder
○Migraines	○Allergies	○Stroke	○Other_____

Please list the relation and age of each family member and their coinciding ailment:_____

_____

What is your marital status? ○Single ○Married ○Divorced ○Separated ○Widow/Widowed

Do you have children? ○Yes ○No If Yes, how many?_____

Name of spouse/partner_____Phone_____

Are you pregnant? ○Yes ○No If Yes, how far along are you?_____

Are you taking any medications? (list)_____

_____

Do you suffer from any disease? (list)_____

_____

Is there any part of your daily routine that you are unable to do? ○Yes ○No

If Yes, please describe:_____

Please list the things that are painful or difficult to do:_____

_____

Do you have an attorney on this claim? ○Yes ○No If Yes, who?_____

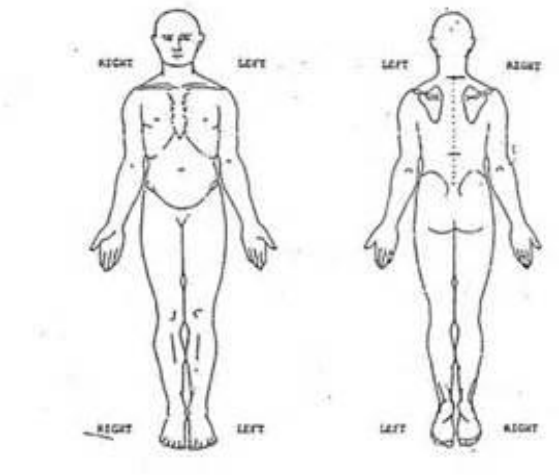
Address_____Phone_____

Claim Number_____Firm Name_____

Your Auto Insurance claims adjuster_____ Phone_____

The other driver's name_____Adjuster_____

Insured name___ _____Driver's name_____



Please diagram your problem areas above using the symbols below and rate the intensity of the pain on a scale of 1-10. A 10 represents the worst pain imaginable. Circle all areas of pain do not fit the descriptions below.

B= Burning
S= Stabbing/Sharp
N= Numbness/Tingling
T= Tightness
A= Aching