INNATE CHIROPRACTIC & WELLNESS

AUTO ACCIDENT INTAKE FORM

Today's Date: _____

Name: _____ Age: _____ Birth Date: _____

Height: _____ Weight: _____ Date accident occurred: _____ Time accident occurred: _____ AM PM

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

Home Phone: (_____)_____ Cell Phone: (_____)_____

Occupation: _____ Email: _____

Emergency Contact Name: _____ Emergency Contact Phone: (_____)_____

Describe how the accident took place: _____

_____

_____

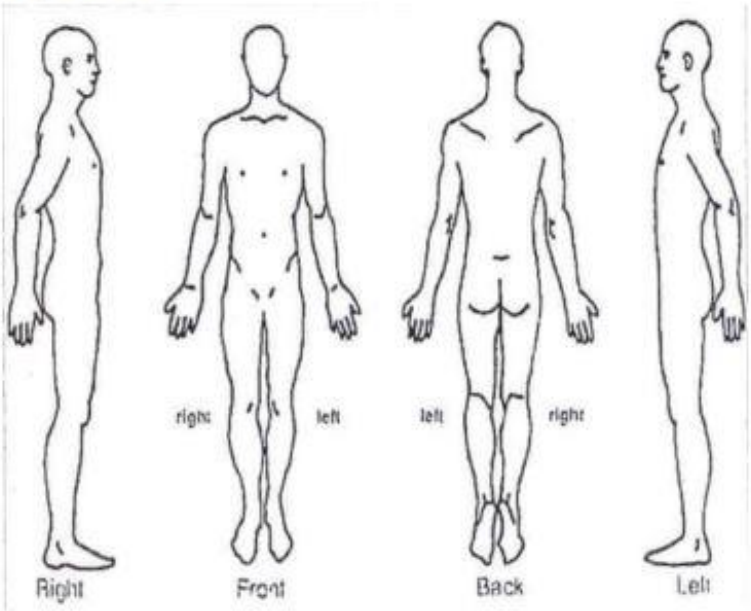
Describe your condition and symptoms caused by the accident: _____

_____

_____

Have you missed work or school due to your injuries or condition? ☐ No ☐ Yes

Please indicate the locations of your pain on the body diagram below.



ON A SCALE OF 1 to 10 with 10 being the worst possible pain, please rate the severity of your symptoms in the body regions that are affecting you.

_____ Headache	_____ Shoulder Pain
_____ Neck Pain	_____ Upper Arm Pain
_____ Upper Back Pain	_____ Lower Arm Pain
_____ Mid Back Pain	_____ Wrist Pain
_____ Lower Back Pain	_____ Hip Pain
_____ Upper Leg Pain	_____ Ankle/Foot Pain
_____ Lower Leg Pain	_____ Other

Auto-Accident Specific Information

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Automobile you were in: Year: _____ Make: _____ Model: _____

Damage to your car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage amount estimate: $ _____ ☐ Minor ☐ Major ☐ Total

Other automobile: Year: _____ Make: _____ Model: _____

Damage to other car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage amount estimate: ☐ Minor ☐ Major ☐ Total

Where did the accident happen? Street names: _____ City, State: _____

Was it: ☐ Controlled intersection ☐ Uncontrolled ☐ Not an intersection

Was there a traffic light? ☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

Speeds: How fast were you going? _____ MPH How fast were they going? _____ MPH

Time of Day: ☐ Day ☐ Twilight ☐ Night

Weather conditions: ☐ Clear ☐ Cloudy ☐ Rainy ☐ Sunny

Street surface: ☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other: _____

Type of impact? ☐ Rear End ☐ Front ☐ Side Impact ☐ Roll Over

Brakes on impact? ☐ Locked Tight ☐ Loosely Applied ☐ None

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Seat Belt/Shoulder harness: ☐ Yes ☐ No **Headrest:** ☐ Yes ☐ No **Headrest Position:** ☐ Up ☐ Down

Is the car equipped with airbags? ☐ Yes ☐ No **Did they deploy?** ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No **Did you brace yourself for impact?** ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact, were you: ☐ Thrown forward ☐ Thrown backward ☐ Thrown sideways ☐ Other: _____

Did your body hit anything in the car? ☐ Yes ☐ No Body part_____ What did it hit? _____

Head trauma? ☐ Yes ☐ No Loss of consciousness? ☐ Yes ☐ No If yes, for how long? _____

Do you remember accident happening? ☐ Yes ☐ No

Hospital: ☐ Yes ☐ No Name of hospital: _____ How long there? _____

Taken by ambulance? ☐ Yes ☐ No

X-rays taken? ☐ Yes ☐ No X-ray areas: ☐ Neck ☐ Mid-back ☐ Low back ☐ Other:

Medication given? ☐ Yes ☐ No Rx: _____

Other instruction from your doctor: _____ Follow-up? _____

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Radiating ☐ Throbbing ☐ Other

What aggravates it? _____

What relieves it? _____

Have you ever had this same or similar condition before? ☐ No ☐ Yes If yes, when? _____

Please describe your condition at that time: _____

_____

Please indicate any other health care providers you have seen for this condition or these symptoms:

Provider's Name	Type of License	Date of last visit
_____	_____	_____
_____	_____	_____

In the past 14 days, have you experienced any of the following:					
□ Headache	□ Dizziness	□ Light Bothers Eyes	□ Diarrhea	□ Head seems too heavy	□ Neck Pain
□ Loss of Memory	□ Clumsiness	□ Feet Cold	□ Neck Stiff	□ Tingling in arms/hands	□ Ears Ring
□ Hands Cold	□ Sleeping Problems	□ Tingling in legs/feet	□ Face Flushed	□ Nausea	□ Back Pain
□ Numbness in arms/hands	□ Buzzing in Ears	□ Constipation	□ Nervousness	□ Numbness in legs/feet	□ Loss of Balance
□ Cold Sweats	□ Tension	□ Shortness of Breath	□ Fainting	□ Fever	□ Fatigue
□ Irritability	□ Loss of Smell	□ Chest pain/rib pain	□ Pain in arms/hands	□ Pain in legs/feet	□ Jaw pain
□ Loss of strength - arms	□ Burning muscle pain	□ Loss of strength - legs	□ Difficulty swallowing	□ Sharp/shooting pain	
OTHER:					
□ Worst Headache Ever	□ Vertigo	□ Double/Blurred Vision	□ Weight Loss	□ Vomiting	□ Minor/Major Fall
□ New Type of Headache	□ Speech Problems	□ Difficulty Walking	□ Stomach Pain	□ Change in Bladder/Bowel	□ Head Trauma

Medical History

Have you ever been to our office before? ☐ No ☐ Yes Date of your last physical exam: _____

List any previous accidents (automobile, on-the-job injuries, falls, sports injuries, etc.) and provide the accident date:

1) _____ Date: _____

2) _____ Date: _____

3) _____ Date: _____

Please list all surgeries, hospitalizations, and serious illnesses: _____

_____

_____

Please list your allergies: _____

What medications are you currently taking?	Please give the purpose for the medication.
_____	_____
_____	_____
_____	_____
_____	_____

Do you now or have ever had:

☐ Heart Disease	☐ Diabetes	☐ Cancer	☐ Stroke	☐ High Blood Pressure	☐ Thyroid Problems
☐ Tuberculosis	☐ Prostate Disorder	☐ Kidney Problems	☐ Asthma	☐ Ulcer	☐ Seizure Disorder

Thank you for taking the time to provide us this information.