BACK IN MOTION, P.S.
CHIROPRACTIC

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Auto accident intake form

Patient Name: _____ DOB (m/d/y): _____ Age: _____ Today's date: _____
Date of accident: _____ Time of accident: _____ am/pm Claim number: _____
Insurance company: _____ Were you driving for work? (circle one): Yes No
In your own words, please briefly describe the accident:
_____
_____
_____
_____

The following questions pertain to YOU and the vehicle you were in:

Make and model of the vehicle: _____ Year: _____

Were any passengers in the vehicle at the time of impact? Yes No If yes, who? _____

Vehicle Type (circle one): Car Van Pickup SUV Station wagon Commercial truck
Other_____

Vehicle size (circle one): Subcompact Compact Mid-size Large Car Small Pick-up Large Pick-up S mall SUV Large SUV
Other_____

Your position in the vehicle (circle one): Driver Passenger:

If you were the passenger, where were you in the vehicle? (circle one or all that apply) Front passenger Rear Passenger Drivers Side Middle Passenger side other_____

Speed of your vehicle (circle one or all that apply) Stopped Parked Slowing Accelerating Other_____

Which direction were you traveling? North South East West

If stopped or slowing, for what reason? Traffic signal Stop sign Pedestrian Parking Traffic Other_____

Approximately how fast was your vehicle moving? _____ Miles per hour Other_____

Collision Type(s), circle one or all that apply:

Front impact Rear impact Side impact Driver side: Front side Middle Rear side
Passenger side: Front side Middle Rear side

The following questions pertain to the OTHER vehicle(s) involved in the accident:

Make and Model: _____ Year: _____

Name of the other driver involved: _____ Their insurance company: _____

Vehicle Type (circle one): Car Van Pickup Sports utility vehicle Station wagon Commercial truck Other_____

Vehicle size (circle one) Subcompact compact mid-size Large Car Small Pick-up Large Pick-up Small SUV Large SUV Other_____

Speed of the other vehicle (circle one or all that apply) Stopped Parked Slowing Accelerating Other: _____

Which direction were they traveling? North South-East West

If stopped or slowing, for what reason? Traffic signal Stop sign Pedestrian Parking Traffic Other: _____

Approximately how fast was their vehicle moving? _____ Miles per hour Other: _____

Collision Type(s), circle one or all that apply: Front impact Rear Impact Side impact Driver side: Front side Middle Rear side
Passenger side: Front side Middle Rear side

Road conditions at the time of the accident:

Road/Street name(s): _____ City/State: _____

Road Conditions (circle one or all that apply): Clean and dry Damp Wet Snow-Covered Ice-covered Patchy snow/ice
Other: _____

Visibility compromised? (circle one or all that apply): Brightness Darkness Rain Snow Fog No compromise in visibility
Other: _____

Use the space below to explain further if necessary

The following questions pertain to the moment of IMPACT:

At the moment of impact, you were (circle one): Totally UNAWARE of the impending accident / AWARE of the impending accident

Were you braced for the impact? Yes No

Were both hands on the steering wheel? (circle one or all that apply): Yes, No If no, which hand was on the steering wheel? Left Right

Please describe the position of your hands on the wheel: _____

Were you wearing a seatbelt? (circle one): Yes No If yes, what type? Shoulder belt Lap Belt Lap and shoulder belt

Did you sustain any bruising or abrasions from the seatbelt? Yes No If yes, please describe: _____

Was your vehicle equipped with airbags? (circle one or all that apply): Yes No If yes, was it/were they deployed? Yes No

Was your vehicle equipped with a headrest? (circle one or all that apply): Yes No

If yes, what position was the headrest in? Low (below head) Middle (even with head) High (top of head)

Did your seat break upon impact? Yes No

Position of your HEAD at the time of impact (circle one or all that apply); Facing straight ahead Tilted Downward Tilted upward Turned to the left Turned to the right Other: _____

Was your head jolted? Yes No If yes, in which direction? Backward then forward Forward then backward To the left To the right Left then right Right then left Other: _____

Position of your BODY at the time of impact (circle one or all that apply): Facing straight ahead, Tilted Downward, Tilted upward, Turned to the left Turned to the right Other: _____

Was your body jolted? Yes No If yes, please describe: _____

Did any part of your body strike the inside of the vehicle? Yes No If yes, please describe: _____

Were any objects thrown around the vehicle? (IE: purses/bags, loose change, luggage etc.) Yes No If yes, please describe: _____

Did your vehicle impact another vehicle/object (IE: median, guard rail, telephone pole etc.)? Yes No If yes, please describe: _____

If you were hit from behind, was your vehicle pushed forward upon impact? Yes No

Did your vehicle leave the road? Yes No if yes, please describe: _____

The following questions pertain to the events that took place AFTER the accident

Did police officers arrive at the scene of the accident? (circle one or all that apply) Yes No

Did anyone receive a citation? Myself The driver of the other vehicle The driver of the vehicle you were in No one

Was a police report filed? Yes No Will be filed

Did EMT's arrive at the scene? Yes No

Did you lose consciousness? Yes No If yes, please describe how long you were unconscious: _____

Where did you go after the accident? (circle one or all that apply): Drove home Was driven home Drove to hospital Was driven to hospital

Was taken to hospital by ambulance Other: _____

How did your vehicle leave the scene? Was towed away Was driven away

Did you sustain any bruises or abrasions from the accident? Yes No If yes, please describe: _____

Did you sustain any broken bones? Yes No If yes, please describe: _____

Did you go to a hospital or urgent care facility at any time following the accident? Yes No If yes, when: _____

What hospital/urgent care? _____

While at the hospital/urgent care, did you receive any X-rays, MRI or CT scans? Yes No

If yes, please describe the type of radiographic evaluation received: _____

What area of the body was evaluated? _____

What treatment was received: _____

Did you receive any follow up care? Yes No If yes, please describe: _____

Since the accident have you had any increase in the following symptoms (please circle all that apply):

Nausea Vertigo Numbness/Tingling Fatigue Headaches Migraines

Change in bowel or bladder function Brain fog Memory loss Vision changes

Please describe if applicable: _____

Did you have any physical complaints before the accident?

Yes No If yes, please Describe: _____

Have you missed work and/or school due to the accident? Yes No

If yes, approximately how much work and/or school have you lost/missed? _____

Have you been able to return to work and/or school? Yes No Full time Part time

Are there any social/recreation activities that were enjoyed prior to the accident that you are now unable to do? Yes No

If yes, please describe the activities that you are no longer able to enjoy due to the accident: _____

_____ _____

Patient signature Date

Parent/legal guardian signature: _____ Date: _____