Vida Chiropractic Center

Date:_____
Patient #_____

AUTOMOBILE ACCIDENT INTAKE FORM

Confidential Data

PERSONAL INFORMATION

Last _____ **First** _____ **Middle Initial** _____ **Birth Date** _____ **Age** _____
Address _____ **City** _____ **ST**_____ **Zip** _____
Phone (Home) _____ **(Work)** _____ **(Cell)** _____
Email _____ **May we send you our online newsletter?** ☐**Yes** ☐**No**
Occupation _____ **Employer** _____
Marital Status: ❑**Married** ❑**Single** ❑**Divorced** ❑**Widow** ❑**Other**_____ **#Children:**_____
Spouse's Name _____ **Business/Employer** _____ **Spouse Phone:** _____
In case of emergency, notify who? _____**Phone #**_____**Relationship:**_____

COLLISION DETAILS

Date of Accident: _____ **Time of Accident:** _____ **am / pm** ❑Daylight ❑Dawn ❑Dusk ❑Dark
Collision type: ❑Front Impact ❑Rear Impact ❑Side Impact: ❑Driver/passenger ❑Front/middle/rear ❑Single vehicle ❑3-or-more vehicles
Who struck who? ❑The other vehicle struck you ❑You struck the other vehicle ❑Other

COLLISION DESCRIPTION

Please describe, to the best of your knowledge, what happened during this collision.

_____
_____
_____
_____

INFORMATION PERTAINING TO YOU AND THE CAR YOU WERE IN

YEAR: _____ MAKE: _____ MODEL: _____
Vehicle Type: ❑Car ❑SUV ❑VAN ❑Pick-up Truck ❑Commercial Truck ❑Other_____
Your position in the vehicle: ❑Driver ❑Front Passenger ❑ Rear passenger Right/Left/Center ❑Other_____
Speed of your vehicle: ❑Stopped ❑Parked ❑Slowing down ❑ Accelerating ❑Steady speed ❑Turning right/left ❑Other_____
If stopped or slowing down, reason: ❑Traffic light ❑Stop sign ❑Traffic ❑Pedestrian ❑Other_____
If moving, estimate the speed of the vehicle you were in: _____**mph** **Total people in your vehicle?**_____

THE OTHER CAR

YEAR: _____ MAKE: _____ MODEL: _____
Vehicle Type: ❑Car ❑SUV ❑VAN ❑Pick-up Truck ❑Commercial Truck Other_____
Speed of your vehicle: ❑Stopped ❑Parked ❑Slowing down ❑ Accelerating ❑Steady speed ❑Turning right/left ❑Other_____
If stopped or slowing down, reason: ❑Traffic light ❑Stop sign ❑Traffic ❑Pedestrian ❑Other_____
If moving, estimate the speed of the vehicle: _____**mph**

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: _____ **Name of their auto insurance:** _____
Policy #: _____ **Claim #:** _____ **Insurance phone #:** _____
Insurance adjuster's name: _____**Email**_____**Phone** _____
Med Pay Benefits ❑Yes ❑No _____ **UM Benefits** ❑**Yes** ❑**No**_____ **UIM Benefits** ❑**Yes** ❑**No**_____

Driver of the other vehicle: _____ **Name of their auto insurance:** _____
Policy #: _____ **Claim#:** _____**Insurance phone #:** _____
Insurance adjuster's name: _____**Email**_____**Phone#**_____

ATTORNEY'S INFORMATION

Attorney's Name:_____**Legal Assistant's Name:**_____
Phone #_____ **Fax #**_____ **Email**_____

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DURING THE ACCIDENT

Road condition at the time of the accident: ❑Wet ❑Dry ❑Snow ❑Icy ❑Other _____
How was the visibility at the time? ❑Good ❑Fair ❑Poor **Due to:** ❑Brightness ❑Darkness ❑Rain ❑Fog ❑Snow
Were you aware of the impending collision? ❑Yes ❑No **Were you able to hold on to something to mitigate the impact?** ❑Yes ❑No
Did you lose consciousness upon impact? ❑Yes ❑No If so, **for how long**?_____
Were you wearing a seatbelt? ❑Yes ❑No **If yes, did you receive any injury or bruise from the seat belt?** ❑Yes ❑No
Did your head hit the head rest during the collision? ❑Yes ❑No **Was the head rest positioned?** ❑Even with head ❑Low ❑High
Did the air-bags deploy? ❑Yes ❑No **If yes, did they strike you?** ❑Yes ❑No **If yes, where?** _____
Which way was your head pointing at the point of impact? ❑Straight ❑Right ❑Left **Which position was your body?** ❑Straight ❑Right ❑Left
Where were your hands? ❑Right/Left on the wheel ❑Both on the wheel ❑Not Applicable
Did any part of your body strike any part of the car? ❑Yes ❑No **If so, explain**_____

AFTER THE ACCIDENT

Did the police come to the accident scene? ❑Yes ❑No **Is there a police report?** ❑Yes ❑No
Where did you go after the collision? ❑Hospital ❑Urgent Care ❑Home ❑Work ❑Private Doctor ❑Other_____
If you went to hospital or doctor, when did you go? ❑Immediately ❑___hours later ❑___days later **Which hospital?**_____
How did you get to the hospital? ❑Ambulance ❑Drove self ❑Someone drove you **How long did you stay in the hospital?** _____
What treatment was given?(collar, splints, medications, etc.)_____
Where x-rays taken? ❑Yes ❑No **What did they recommend for follow-up care?** _____
Was any other doctor consulted after your accident? ❑Yes ❑No **If yes, please, complete the information below:**
Dr. _____ **Specialty:**_____ **Date first seen:**_____
Type of treatment:_____ Treatment frequency:_____ How long did you treat?_____days/months

SYMPTOMS IMMEDIATELY FOLLOWING THE ACCIDENT

Please, mark if you experienced any of the following: ❑Confusion ❑Dizzy ❑Nauseated ❑Blurred vision ❑Ringing in ears ❑Loss of balance
Please, mark if you felt pain in any of these areas: ❑Headaches ❑Neck ❑Upper Back ❑Mid back ❑Low back ❑Shoulders ❑Elbows ❑Wrists
❑Ribs ❑Chest ❑Abdomen ❑Pelvis ❑Buttocks ❑Hips ❑Knees ❑Ankles ❑Other: _____
Were there any symptoms after the accident that have now resolved?_____
Have you done any of the following since the accident? ❑Ice ❑Heat ❑Medications ❑Rest ❑Massage ❑Other_____

PRESENT SYMPTOMS

PLEASE, CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

❑ dizziness	❑ difficulty sleeping	❑ neck stiffness	❑ neck pain
❑ nausea	❑ irritability	❑ jaw pain/clicking	❑ upper back pain
❑ headache/s	❑ fatigue	❑ numb/tingling arms	❑ mid back pain
❑ vision problems	❑ tension	❑ numb/tingling legs	❑ lower back pain
❑ buzzing in ears	❑ loss of balance	❑ shortness of breath	❑ chest pain
❑ ringing in ears	❑ loss of memory	❑ stomach upset	❑ leg/knee/foot pain
❑ loss of smell	❑ any bruises	❑ head feels heavy	❑ arms/shoulder/wrist pain
❑ loss of taste	❑ any cuts	❑ radiating pain	❑ depression

❑ others_____

PAST HEALTH HISTORY

PLEASE, CHECK IF YOU HAVE A HISTORY OF THE FOLLOWING SYMPTOMS/DISEASES IN THE PAST

❑ difficulty sleeping	❑ slipped disc	❑ menstrual cramps	❑ osteoporosis	❑ liver disease
❑ arthritis	❑ pinched nerve	❑ irregular periods	❑ thyroid disease	❑ kidney disease
❑ seizures	❑ cancer	❑ infertility	❑ whooping cough	❑ anemia
❑ migraines	❑ dizziness	❑ depression	❑ heart disease	❑ diabetes
❑ neck pain	❑ heart problems	❑ allergies	❑ excessive thirst	❑ asthma
❑ mid back pain	❑ high blood pressure	❑ stuffy nose	❑ frequent nausea	❑ heartburn
❑ low back pain	❑ ankle swelling	❑ weight loss	❑ vomiting	❑ gas/bloating
❑ headaches	❑ cold extremities	❑ poor appetite	❑ prostate problems	❑ colitis
❑ feet pain/tingling	❑ blurred vision	❑ excessive appetite	❑ bladder trouble	❑ irritable bowel
❑ hand pain/tingling	❑ vision problems	❑ nervousness	❑ breast pain/lumps	❑ constipation

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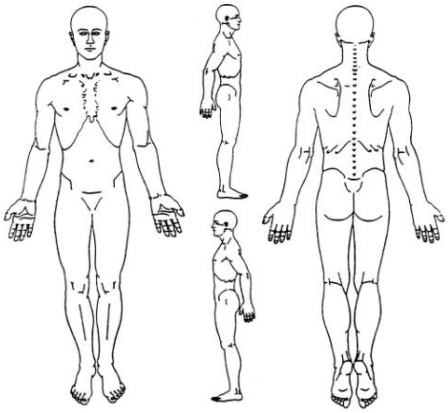
CURRENT COMPLAINTS List current symptoms separately in order of severity.

1º Body Part:_____
Date symptom first appeared: _____
How often do you experience these symptoms? ❑Constant 100% ❑Frequent 75%
❑Intermittent 50% ❑Occasional 25% ❑Rare 10%
What makes symptom increase? _____
What makes symptom decrease?_____
Type of pain? ❑Sharp ❑Dull ❑Aching ❑Burning ❑Throbbing ❑Numb
❑Other_____
Where does pain radiate to? _____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)
0◇◇◇1◇◇◇2◇◇◇3◇◇◇4◇◇◇5◇◇◇6◇◇◇7◇◇◇8◇◇◇9◇◇◇10

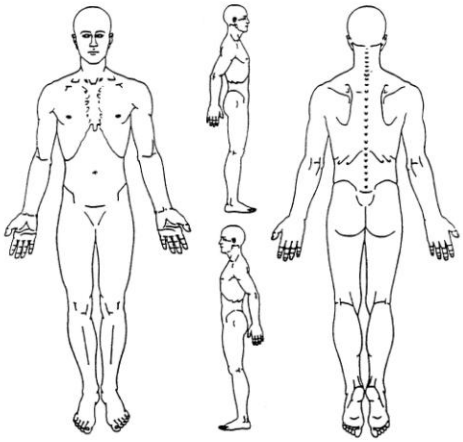
PLEASE, MARK AREAS OF PAIN ON IMAGE BELOW



2º Body Part:_____
Date symptom first appeared: _____
How often do you experience these symptoms? ❑Constant 100% ❑Frequent 75%
❑Intermittent 50% ❑Occasional 25% ❑Rare 10%
What makes symptom increase? _____
What makes symptom decrease?_____
Type of pain? ❑Sharp ❑Dull ❑Aching ❑Burning ❑Throbbing ❑Numb
❑Other_____
Where does pain radiate to? _____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)
0◇◇◇1◇◇◇2◇◇◇3◇◇◇4◇◇◇5◇◇◇6◇◇◇7◇◇◇8◇◇◇9◇◇◇10

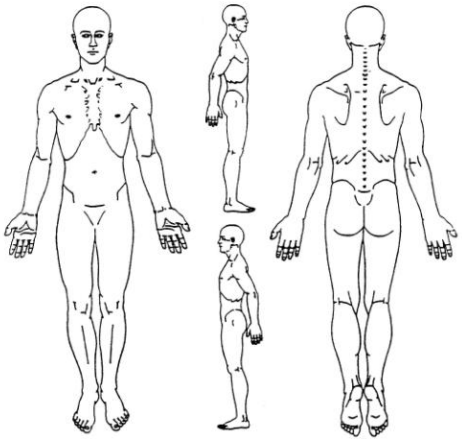
PLEASE, MARK AREAS OF PAIN ON IMAGE BELOW



3º Body Part:_____
Date symptom first appeared: _____
How often do you experience these symptoms? ❑Constant 100% ❑Frequent 75%
❑Intermittent 50% ❑Occasional 25% ❑Rare 10%
What makes symptom increase? _____
What makes symptom decrease?_____
Type of pain? ❑Sharp ❑Dull ❑Aching ❑Burning ❑Throbbing ❑Numb
❑Other_____
Where does pain radiate to? _____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)
0◇◇◇1◇◇◇2◇◇◇3◇◇◇4◇◇◇5◇◇◇6◇◇◇7◇◇◇8◇◇◇9◇◇◇10

PLEASE, MARK AREAS OF PAIN ON IMAGE BELOW



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OCCUPATIONAL INFORMATION

Job involves: ❑Sitting ❑Standing **How long?** _____hs. ❑Lifting **How much?** _____ lbs. ❑Bending ❑Twisting ❑Turning ❑Stooping
Physical activity at work: ❑Sedentary ❑Light manual labor ❑ Manual labor ❑Heavy manual labor
Have you missed any time from work due to the accident? ❑Yes ❑No **If yes, how many days?** _____ **Dates:**
_____to_____
Are your work activities restricted as a result of this accident? ❑Yes ❑No **If yes, please explain**_____
Do any of your work activities aggravate your present main complaints? ❑Yes ❑No **If yes, please explain**_____

PRESENT HISTORY

Do you smoke? ❑Yes ❑No If yes, how many packs per week?_____ **Have you ever smoked in the past?** ❑Yes ❑No When did you quit?_____
Do you consume alcohol? ❑Yes ❑No If yes, how many drinks per week? _____
Do you consume caffeine? ❑Yes ❑No If yes, how many drinks per day? _____
Do you exercise? ❑Yes ❑No If yes, how many times per week and what type? _____
Do you have a high stress level? ❑Yes ❑No If yes, list reasons:_____

CURRENT MEDICATIONS OR VITAMINS

Please list any medications or vitamins you are currently taking (including dosage).

_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____
_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____
_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____
_____ **Frequency:**_____ **Dosage:** _____ **What is this for?** _____

PRIOR SERIOUS ILLNESS AND PREVIOUS ACCIDENTES/COLLISIONS

INJURIES SUSTAINED/ILLNESS	DATE OF INJURY	CITY, STATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

X-RAY CONSENT_FEMALES ONLY

At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographic pictures if necessary.

_____ _____
Patient Signature **Date**

CONSENT TO TREAT A MINOR

I hereby authorize the doctor(s) at Vida Chiropractic Center, and whomever they designate as assistants, to administer care to my child.
Name of Child / Minor (please, print)_____
Name of Parent / Guardian (please, print) _____
Parent / Guardian Signature: _____ **Date**: _____

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

_____ _____
Patient Signature **Date**