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Auto Accident New Patient Intake

Demographics

Name:_____ Date of Birth:___/___/_____ Age:____Gender:____

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

Primary Phone:_____ Type of phone: Home Work Mobile

Secondary Phone:_____ Type of phone: Home Work Mobile

Email:_____ Social Security Number:_____

Marital Status: Single Married Divorced Widowed Name of Spouse:_____

Your Occupation:_____ Your Employer:_____

How did you hear about our office?

Referred by_____ Yelp Facebook Attorney Other_____

Emergency Contact Name:_____ Number:_____
Relation:_____

Chiropractic Experience

Have you ever been to a chiropractor? Yes No (If No, skip to the next section)

Date of Care: _____to_____ Reason for Care: Injury/Pain Relief Wellness/Lifestyle

What were the results? _____

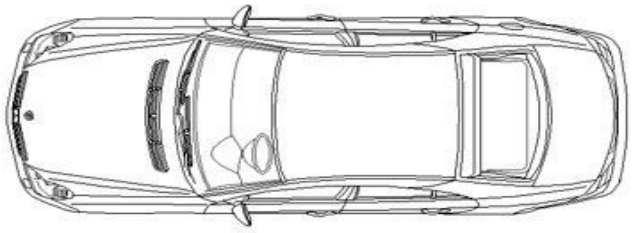
Auto Accident Information

Accident Date: _____ Were you deemed that at-fault party? (circle one) YES NO TBD

Location of Accident (Cross Streets):

_____

Where on your vehicle did the impact take place? (Write impacted areas and mark diagram with an "X" in all appropriate areas) _____



Which direction were you traveling at the time of the accident? North South East West

How fast were you traveling at the time of impact? Stopped OR _____mph

What was the time of the accident? ____:_____ A.M. P.M. (circle one)

Were you working at the time of the accident? YES NO

What were the conditions at the time of the accident? (circle all that apply)

Clear Dry Rainy Overcast Night/Dark Good visibility Poor visibility

Other:_____

Were you wearing your seat belt? YES NO

Does your vehicle have a headrest? YES NO

If yes, What was the position of the headrest? _____

Which direction were you looking at the time of accident? (circle one)

Straight ahead Slightly Right Slightly Left Down Up Other:_____

Were you pressing the brake pedal at the time of the accident? YES NO

Were you braced at the time of impact? YES NO

Did the airbags deploy? YES NO I do not have airbags in my vehicle

Did your body strike anything in the vehicle? YES NO

*If yes, please describe what area of your body struck what area of the vehicle:

_____

Did you lose consciousness? YES NO

Were you bleeding? YES NO

*If yes, where were you bleeding?_____

Did you receive emergency care at the scene of the accident? YES NO

If Yes, who administered care?_____

How did you leave the scene of the accident?

Ambulance Drove own vehicle away Picked up at the scene of the accident by _____

Taken in tow truck Drove home by police Walked home Took public transportation

Where did you go immediately following the accident?

Home Urgent Care/Hospital Work Other:_____

What were your symptoms at the scene of the accident? (explain)

_____

If you have developed new symptoms since the scene of the accident, please describe:

_____

_____

On a scale from 1-10 (10 being the worst) how would you rate your pain?

Have you seen another health care provider for this accident? YES NO

If yes, please provide the information below:

Name(s) of other facility and/or doctor:_____

Date of care:_____

Address of facility and/or doctor:_____

Type of doctor seen: Primary Care Urgent Care/Emergency Specialist:_____

Phone number of facility and/or doctor:_____

Name(s) of other facility and/or doctor:_____

Date of care:_____

Address of facility and/or doctor:_____

Type of doctor seen: Primary Care Urgent Care/Emergency Specialist:_____

Phone number of facility and/or doctor:_____

Insurance Information

Name of **your auto** insurance:_____

Phone number: _____

Policy number: _____

Claim number: _____

Name of **other party's auto** insurance*: _____

*Not needed if you were deemed the at-fault party

Phone number*: _____

Claim number*: _____

Have you obtained an attorney? (circle one) YES NO

If yes, complete the following:

Name of the attorney: _____

Attorney's number: _____

Attorney's address:_____

General Health & Lifestyle

Have you stopped doing any activities since the onset of the condition(s)/concern(s)? Yes No

Please list (if applicable):_____

Please **circle** any of the following conditions that **YOU** have experienced:

Physical or Sexual Abuse	Heart Condition	Food Sensitivity
Recent Infection/Fever	Respiratory Condition	Digestive Condition
Jaw Pain	Difficulty Concentrating	Stroke
Headaches	Kidney Condition	Weight Gain/Loss
Dizziness	Bladder Condition	Skin Condition
Fainting Spells	Menstrual Issues	Arthritis
Seizure	PMS	Diabetes
Prolonged Fatigue	Prostate Condition	Cancer
Fibromyalgia	Asthma	Ringing of Ears
Blood Pressure Issues	Allergies	Sinus Condition
Thyroid Condition	HIV/AIDS	Attention Issues
Depression	Anxiety	Addiction Issues
Sexual Dysfunction	Heartburn	Vision Issues
Muscle/Joint pain other than	Sports Injury	High Cholesterol

WOMEN ONLY: Are you currently pregnant? Yes No

What have you done to improve your state of health – body and/or mind?: **Circle all that apply**

Massage Pilates Nutritional Supplements Weight Training/Lifting Running
Dietary Modifications Metabolic Detox/Cleanse Acupuncture Weight Loss Program
Meditation Family/Marriage/Personal Therapy Yoga Other Exercise:_____

Do you sleep well? Yes No
How many hours do you sleep?_____
Do you sleep on your stomach? Yes No
How many hours a day do you sit?_____

How many cups of coffee a day do you drink?____
How many sodas a day do you drink?_____
How many glasses of water/day do you drink?____
How many times a week do you eat fast food?____

Family History

Please **circle** any of the following conditions that a **FAMILY member** has experienced:

Diabetes	Stroke	Cancer
Arthritis	Obesity	Anxiety
Depression	Blood Pressure Issues	High Cholesterol

By signing below, I state that the information provided above is accurate and true

Patient Signature:_____ Date:_____

FOR OFFICE STAFF USE ONLY:

Height:_____inches Weight:_____pounds