Motor Vehicle Accident
Chiropractic Intake Form

Name: _____ DOB _____ Date: _____

Insurance Information:
Name of Insurance Company: _____

Claims #: _____ Adjusters Name: _____

Phone # to reach Adjuster: _____ Claim open for Medical Billing: YES NO

Claims Filing Address: _____

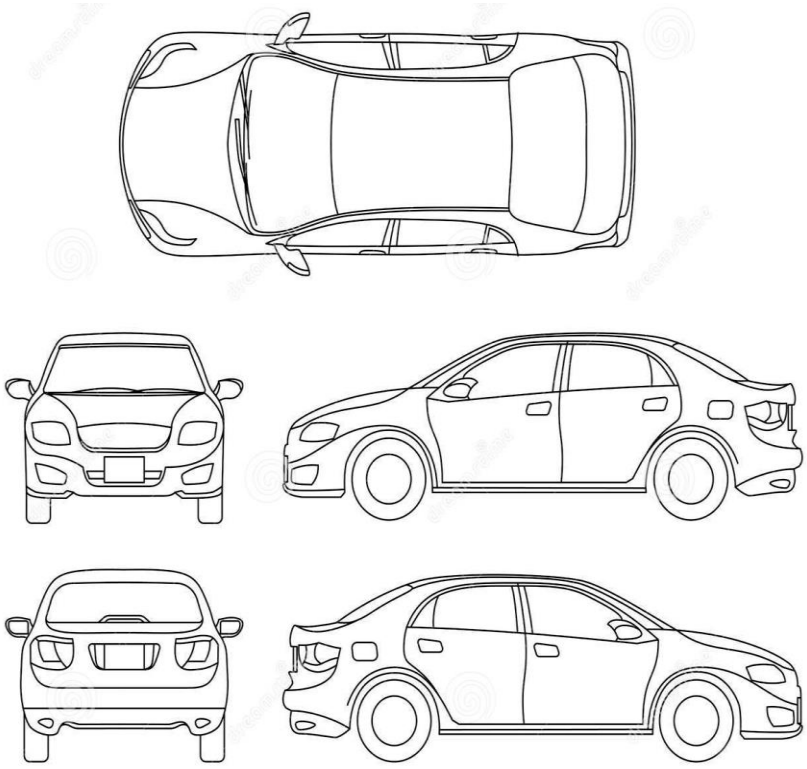
Other Party Insurance Company (If Applicable):
Name of Insurance Company: _____ Ins Phone #: _____

Secondary Claim #: _____

At Fault Party's Name: _____ Phone #: _____

ACCIDENT HISTORY:

Date of Accident: _____ Time of Accident: _____ AM or PM



State how the accident happened in your own words:

_____

_____

_____

_____

_____

_____

_____

← **Please indicate where your car was damaged to the best of your ability.**

Patient Signature: _____ Date: _____

ACCIDENT HISTORY:

Type of Vehicle: _____Year of Vehicle: _____

Were you driving the car? YES NO If NO, who was? _____

Did your vehicle strike anything else? (Tree, another car, side railing, etc.)_____

What were the weather conditions like? _____

How fast were you driving? _____

Were you driving distracted? _____

Were you wearing a seatbelt? YES NO

Did the Air Bags go off? YES NO

Did Police arrive at the accident? YES NO

Did EMS arrive at the accident? YES NO

What was the extent of damage done to your car? _____

What was the other type of vehicle involved in the accident? _____ Year_____

What was the extent of damage done to the other car? (If known) _____

INJURY HISTORY:

Did you hit any part of your body during the collision? (Head hit dashboard, chest hit steering wheel, etc.)

_____

Where are you feeling the pain now?

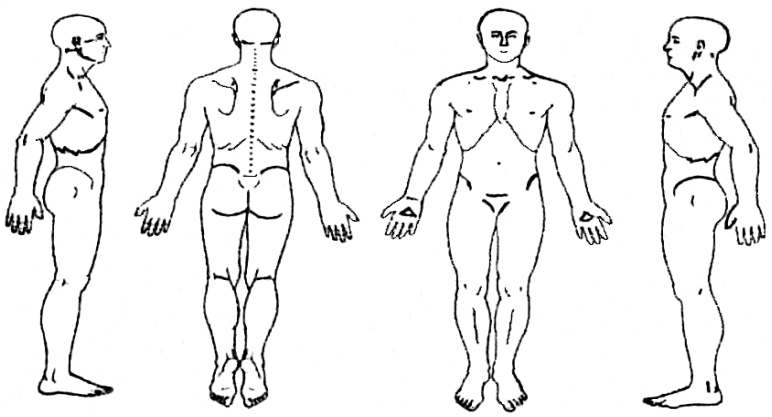
Condition #1 Main complaint: _____

Condition #2: Second complaint: _____

Condition #3: Third complaint: _____

Condition #4: Fourth complaint: _____

Please mark the image where you are feeling pain or discomfort. →



OFFICE USE ONLY
Height:
Weight:
Blood Pressure:
Pulse:

Patient Signature: _____ Date: _____

Please Rate the Pain of the complaints in the order listed above from 0-10:

(0= No pain) (10= Very Severe Pain)

Condition #1	0	1	2	3	4	5	6	7	8	9	10
Condition #2	0	1	2	3	4	5	6	7	8	9	10
Condition #3	0	1	2	3	4	5	6	7	8	9	10
Condition #4	0	1	2	3	4	5	6	7	8	9	10

Please Rate the Frequency at which you experience the pain throughout the day 0-100%:

(0-25%= zero-occasionally) (100%= Constant)

Condition #1	0%	25%	50%	75%	100%
Condition #2	0%	25%	50%	75%	100%
Condition #3	0%	25%	50%	75%	100%
Condition #4	0%	25%	50%	75%	100%

Please Describe the Pain:

Condition #1	Sharp	Dull	Burning	Aching	Throbbing	Numb	Tingling
Condition #2	Sharp	Dull	Burning	Aching	Throbbing	Numb	Tingling
Condition #3	Sharp	Dull	Burning	Aching	Throbbing	Numb	Tingling
Condition #4	Sharp	Dull	Burning	Aching	Throbbing	Numb	Tingling

When do you feel symptoms are worse? Morning Afternoon Night **Other:** _____

What makes your symptoms feel better? _____

What makes your symptoms feel worse? _____

Has there been any new symptoms? _____

Did you lose consciousness during the accident? _____

Were you taken to the hospital after the accident? _____

Has your primary care doctor or any other doctor checked you out after the accident? _____

Name of Doctor: _____

Are you still under care? YES NO

Did you receive any treatments after the accident to help with the conditions you are presenting with today?

_____

What are your main physical limitations during the day? (Walking, stairs, sleeping, etc): _____

_____