CONFIDENTIAL
AUTO ACCIDENT/
PERSONAL INJURY INTAKE

INFORMATION PROVIDED ON THIS INTAKE WILL BE USED FOR MVA BILLING PURPOSES AS COMPLIANT WITH HIPAA

Patient Information:

Today's Date____________Name___________________________________ Age______________________
Home Phone_______________________________Cell/Work Phone_________________________________
Address____
Email ______________________________Social Security #_____________________Date of Birth_________
Gender _______________ Height _____' _____" Weight _____________ lbs
Occupation ___________________________ Employer____
Marital Status _________________ Names/Ages of Children ______________________________________

If minor, name of parent or guardian ____
Who should we contact in case of an emergency? ____
Relationship to Patient _____________________________ Phone ___________________________________
Address____
How did you hear about our office? ____

Have you ever seen a chiropractor before? YES/NO If yes, whom/when?______________________________

Health Insurance Information:

Insurance Company ___________________ Policy number ______________________________________
Policy Holder's Name __________________ Social Security #____________________________________
Address ______________________________ Phone ____

Personal Auto Insurance Information:

Insurance Company ___________________ Policy number_______________________________________
Address _______________________________________ Phone _______________________________________
Adjuster Name_________________________ Claim # ____

At Fault Insurance Information: *(If you were at fault, leave blank)*

Insurance Company ____________________ Policy Number ____________________________________
Address _______________________________________ Phone _______________________________________
Adjuster Name _________________________ Claim # ____

Attorney Information:

Name ________________________________ Phone ____
Address ____

Accident Information:

Date of Accident ________________ Time of Accident _____________ AM PM

Was it reported to the police? YES/NO Was a traffic violation issued? YES / NO To whom?______________

Where did the accident occur? (Street/Town)____

Were there other witnesses? YES/NO Additional Passengers in your vehicle? YES/NO #____________

Make/model/owner of vehicle you were in? ____

Please explain in detail how the accident occurred ____

____

____

Please list symptoms felt immediately after the accident ____

____

In which direction were you headed? N S E W Approx. speed of your vehicle _____________ MPH

At Time of Accident

Did the impact to your vehicle come from the: FRONT REAR RIGHT LEFT OTHER

During impact, were you facing: RIGHT LEFT FORWARD

Were you EXPECTING or SURPRISED by the impact?

Were you the DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER?

Were you wearing a seat belt? SHOULDER HARNESS LAP HARNESS

Was the vehicle equipped with air bags? YES NO Did they inflate? YES NO

In relation to the base of your skull, where was the headrest? ABOVE BELOW AT BASE

What did your vehicle impact? ANOTHER VEHICLE OTHER ______________________________________

Did any part of your body strike anything in the vehicle? YES NO Describe__________________________

Did the accident render you unconscious? YES NO If yes, for how long? ___________________________

If another vehicle hit yours, appx what speed was it moving? __________MPH Make/Model? ______________

Post-Injury Information:

Have you seen any other doctor(s) since the accident? YES NO Name ________________________________

When did you go? IMMEDIATELY NEXT DAY 2 DAYS PLUS Date:________________________________

How did you get there? AMBULANCE PRIVATE TRANSPORTATION

Name of hospital and/or attending doctor: ____

Please describe any treatment you received ____

Were X-Rays done? YES NO An MRI? YES NO CAT scan? YES NO

Was medication prescribed? YES NO If yes, what? ____

Have you missed any work since the accident? YES NO Date(s) ____

Are your work activities restricted as a result of your injury? YES NO __________________________________

Indicate the symptoms that are a result of this accident:

DIZZINESS DIFFICULTY SLEEPING JAW PROBLEMS NAUSEA MEMORY LOSS ARM/SHOULDER PAIN IRRITABILITY BACK PAIN HEADACHE(S) NUMB HANDS/FINGERS FATIGUE LOW BACK PAIN BLURRED VISION TENSION CHEST PAIN BACK STIFFNESS BUZZING IN EAR NECK PAIN SHORT BREATH LEG PAIN EARS RINGING NECK STIFF STOMACH UPSET NUMB FEET/TOES OTHER: ____

Did you ever experience similar symptoms prior to the accident? YES/NO Explain _______________________

____

Has your condition IMPROVED WORSENED or STAYED SAME since the accident?

Is your condition affecting your WORK SLEEP or DAILY ROUTINE? Please explain ______________
____

Please indicate your degree of difficulty (on a scale of 1-5, with 1 being comfortable, 3 being uncomfortable, and 5 being painful) in performing the following activities:
___ Lying on Back ___ Lying on Side ___ Lying on stomach ___ Sitting___ Standing ___ Stretching
___ Lovemaking ___ Walking___ Running ___ Sports ___ Working ___ Lifting___ Bending ___ Kneeling
___ Pulling ___ Reaching

How many hours are in your normal workday? _____________
Please indicate your daily job duties and any activities that you are occasionally asked to perform:
STANDING OPERATING EQUIPMENT DRIVING SITTING TWISTING
WORK W/ARMS ABOVE HEAD WALKING CRAWLING TYPING LIFTING BENDING

What positions can you work in with minimum physical effort, and for how long?
Do you work with others who can help you with any heavy lifting? YES NO
While in recovery, are there any light duty tasks you could request? YES NO

Health History
Please list any and all major medical conditions you currently and previously have suffered from:
____
____
____
____
Please list any allergies. ____
Please list previous surgeries and dates ____
____
Please list any past motor vehicle accidents or traumas and dates _________________________________
Is there anything else about your health history or family health history that you feel is important to Share?____
____
Do you exercise? YES NO How often? ___________________ What type ______________________
Are you on a special diet? YES NO If Yes, how long ___________ What type ____________________
Do you smoke? YES NO How much?__________________ How long? _____________________

WOMEN ONLY
For women: Are you taking birth control? YES NO If yes, what type _____________________________
Are you pregnant? YES NO Nursing? YES NO Date of Last Menstrual Period _____________
I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT I AM NOT PREGNANT AND GIVE PERMISSION TO THE DOCTORS AT NEW LEAF CHIROPRACTIC TO PERFORM AN X-RAY EVALUATION. I HAVE BEEN ADVISED THAT X-RAYS CAN BE HARMFUL TO AN UNBORN CHILD.

Printed Name _____________________________________ Date _________________________________
Signature ____________________________________ Witness __________________________________
Signature of parents or guardian if under 18 years of age ____