Parlopino chiropractic

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Personal Injury Intake Form-Car Accident

Name _____Date _____

Have you missed any days at work? ___ Yes ___No

Dates Missed: _____

Date of Accident _____ Time of Accident _____AM/PM

Please Describe the accident in your own words:

_____

_____

Were you the: ___ Driver ___ Front Passenger ___ Rear Passenger ___ Pedestrian

Accident Site: _____ Driving Conditions: ___Dry ___Wet ___Ice ___Other:_____

Visibility: ___Poor ___Fair ___Good ___Other: _____Was your vehicle moving? ___Yes ___No

If yes, speed of vehicle? _____MPH

IMPACT

Did your car impact another vehicle? ___Yes ___No

Did your body strike anything inside the vehicle? ___Yes ___No

If yes, please explain: _____

How were you sitting before impact? _____

Did you see the accident coming? ___Yes ___No

Did you brace for impact? ___Yes ___No

Was your car breaking? ___Yes ___No

CAR DETAILS

Make and model of your car: _____

Were you wearing a seatbelt? ___Yes ___No

Were shoulder harnesses being worn? ___Yes ___No

Did the airbags inflate? ___ Yes ___No

Did your seat have a headrest? ___Yes ___No

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

PASSENGERS

Were there any other passengers/people in your car? ___Yes ___No

Name & Age of passenger: _____

Name & Age of passenger: _____

PATIENT CONDITON

Were you unconscious after the accident? ___Yes ___No If yes, for how long? _____

Could you move all parts of your body? ___Yes ___No

If no, which parts couldn't you move and why? _____

Were you able to get out of the car and walk unaided? ___Yes ___No

If no, why not? _____

Did you get any bleeding cuts? ___Yes ___No If yes, where?_____

Did you get any bruises? ___Yes ___No If yes, where? _____

Please describe how you felt,

1) immediately after the accident? _____

2) Later that day? _____

3) The next day? _____

HOSPITALIZATION

Did you go to the hospital immediately after the accident? ___Yes ___No

How did you get there?

___ambulance ___police ___someone else drove me ___drove own car

When did you go? ___Immediately after the accident ___Next day ___2 days +

Hospital Name: _____ Name of Doctor: _____

Treatment received:_____

Medications given: _____X-rays taken: _____

ADDITIONAL TREATMENT

Did you seek any additional treatment? ___Yes ___No If yes, who did you see? _____

Date of visit?_____ Treatment received:_____

SYMPTOMS

If you have had any of the following symptoms since the accident, please check off:

Rate each symptom with a number on a scale of 0-10 with 10 being the worst

□ Arm/Shoulder pain _____	□ Foot/toe numbness _____	□ Dizziness _____
□ Low back pain _____	□ Neck stiffness _____	□ Ear ringing _____
□ Neck pain _____	□ Headaches _____	□ Memory Loss _____
□ Upper back pain _____	□ Irritability _____	□ Jaw problems _____
□ Chest pain _____	□ Nausea _____	□ Sleep difficulty _____
□ Leg pain _____	□ Stomach upset _____	□ Blurred vision _____
□ Hand/finger numbness _____	□ Chest pain _____	□ Shortness of breath _____

Past health history: Place an x if it applies and describe:

□ None related to current complaints	□ Hospitalized	□ Surgery
	□ Work Accident	□ Illness
□ Other auto accident(s)		

Describe condition and treatment

_____

_____