Highland Chiropractic Family Care

MOTOR VEHICLE INTAKE FORM

Please print clear and fill in completely

Patient Name:_____**Date:**_____/_____/_____

Date of accident:____/_____/____ **Age:**_____ ☐ **Male** ☐ **Female D.O.B:**___/___/_____.

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Address:_____

STREET CITY ZIP

Tel # : (H)_____(W)_____(Cell)_____

Spouses name:_____**Number of children:**_____

Your Employer:_____**Occupation:**_____

Employers Address:_____

CITY STATE

E-mail Address:_____

Primary Care Physician:_____**Tel:**_____

Most recent visit:_____/_____/_____

Mark physical &/or administrative duties that cause pain: ☐ **lifting** ☐ **bending** ☐ **twisting** ☐ **Prolonged postures** ☐ **normal sleeping postures**

Have you stopped working since the accident: yes no **If no, are you working in distress:** yes no **If yes, is it because of finances:** yes no

What else have you been unable to do since the accident: ☐ **Exercise** ☐ **Play sports** ☐ **Household chores** ☐ **Take care of children** ☐ **Play with children**

What other activities have you been unable to do because of the accident:_____

_____

Do you smoke cigarettes: yes no **if yes, how many:**_____ **Do you drink alcohol:** yes no **if yes, how often and how much:**_____

Past medical history: Any other motor vehicle accidents: yes no

If yes, what were the dates and what were the injuries:_____

_____

Have you had any previous injuries (work – sports – home chores) to your neck, middle or lower back or any extremities: yes no **If yes, please describe injury; its date; and where it occurred:**_____

_____

_____

Have you ever been treated for a medical condition: yes no **If yes, when and for what condition and did it involve surgery:**_____

_____

_____

Are you currently taking any medication: yes no **If yes, what medication and for what condition:**_____

For Women: Are you taking birth control: yes no **Are you pregnant:** yes no

If yes, how long:_____**Nursing:** yes no

Have you ever been treated by a Chiropractic Doctor: no yes **If yes, for what & where:**_____

Pertaining to the Motor Vehicle Accident did you receive any care shown below:

To Hospital by: ☐ Ambulance ☐ Private transportation **by who:**_____

Name and location of the Hospital:_____

What was done at Hospital: X-rays (of what):_____

Medication: (what)_____

Anything else:_____

Have you seen any other doctors / nurses since accident and what was done:_____

_____

_____

Has your condition been getting: ☐ worse ☐ staying the same ☐ better

Indicate the areas of pain/stiffness that still exist as a result of this accident:

☐ neck ☐ shoulders ☐ middle back ☐ lower back ☐ hand ☐ wrist ☐ elbow
☐ arm ☐ hip ☐ buttock ☐ thigh ☐ knee ☐ leg ☐ ankle ☐ chest ☐ jaw

Indicate other symptoms as a result of this accident:

☐ headaches ☐ dizziness ☐ ringing in ears ☐ memory loss ☐ blurred vision
☐ nausea ☐ tension ☐ fatigue ☐ numbness/tingling (where)_____

Weight: _____lbs **Height:**_____

Auto Accident Injury Information

What was your position in the vehicle?

( ) The driver **( )** The rear passenger
( ) The front passenger **( )** A pedestrian **( )** Other: _____

What type of vehicle were you driving?

( ) Compact car ( ) Full size car ( ) Full size truck ( ) Full size van
( ) Mid size car ( ) Compact truck ( ) Mini van ( ) Compact sport utility vehicle
( ) Full size sport utility vehicle ( ) Motorhome
( ) Motorcycle ( ) Bicycle ( ) Other: _____

What speed were you traveling at the time of the accident?

( ) Stopped at a stop light ( ) At a complete stop
( ) Slowing down at an intersection ( ) Moving slowly
( ) Traveling at approximately ___ mph ( ) Merging into traffic
( ) Traveling faster than 65 mph ( ) Other: _____

Who hit whom?

( ) Was struck by another vehicle ( ) Struck a stationary object
( ) Struck another vehicle ( ) Other: _____

What was your vehicle's point of impact?

( ) On the front ( ) On the left front ( ) On the rear ( ) On the left rear
( ) On the right front ( ) On the middle front ( ) On the right rear ( ) On the middle rear

( ) On the right side ( ) On the rear right side ( ) On the left side
( ) On the front right side ( ) On the middle right side ( ) On the front left side
( ) On the rear left side
( ) On the middle left side ( ) Other: _____

What speed was the other vehicle traveling?

( ) Stopped at a stop light ( ) At a complete stop
( ) Slowing down for an intersection ( ) Moving slowly
( ) Merging into traffic ( ) Traveling faster than 65 mph
( ) Traveling at approximately ___ mph ( ) Other: _____

What was the other vehicle's point of impact?

( ) On the front ( ) On the left front ( ) On the rear
( ) On the right front ( ) On the middle front ( ) On the right rear
( ) On the left rear ( ) On the right side ( ) On the rear right side
( ) On the middle rear ( ) On the front right side ( ) On the middle right side

( ) On the left side ( ) On the rear left side
( ) On the front left side ( ) On the middle left side ( ) Other: _____

Were you wearing seat restraints?

( ) Was wearing a full lap and shoulder restraint
( ) Was wearing a shoulder restraint
( ) Was wearing a lap restraint
( ) Was not wearing any seat restraints
( ) Other: _____

What position were your vehicle head rests in?

( ) Did have a head rest which was adjusted in the lowest position
( ) Did have a head rest which was adjusted in the middle position
( ) Did have a head rest which was adjusted in the highest position
( ) Was not equipped with a head rest
( ) Other: _____

Did your air bag deploy?

( ) Air bags were deployed
( ) Air bags were not deployed
( ) Other:_____

Were you prepared for the impact?

( ) Was completely surprised by the accident
( ) Saw the collision coming and braced appropriately
( ) Saw the collision coming
( ) Other: _____

What position was your body in just prior to impact?

( ) A straight position
( ) A position rotated to the left
( ) A tilted forward position
( ) A position rotated to the right
( ) A position that cannot be remembered
( ) Other: _____

What happened to your body the moment of impact?

( ) Body was tensed for impact
( ) Body violently torqued and twisted
( ) Body whipped violently forward and backward
( ) Body was thrown over the seat
( ) Body was thrown from the vehicle
( ) Body was thrown violently from side to side
( ) Body was pinned in the vehicle
( ) Body was badly cut and bruised
( ) Other: _____

What was your mental/emotional state immediately following the accident?

( ) Was not rendered unconscious by the impact of the accident
( ) Was not rendered unconscious but was shaken and disoriented
( ) Was not rendered unconscious but was shaken up
( ) Was not rendered unconscious but was disoriented
( ) Was rendered unconscious by the impact of the accident
( ) Other: _____

Did you receive medical attention at the scene of the accident?

( ) Did receive medical attention
( ) Did not receive medical attention **( )** Other: _____

Where did you go immediately following the accident?

( ) Was taken to the hospital **( )** Was taken to a personal physician
( ) Was taken home **( )** Was taken to this office
( ) Resumed activities
( ) Other: _____

List each of your body parts that struck the following vehicle parts during the accident.

Dashboard:

( ) Right side of the head **( )** Right arm **( )** Right wrist **( )** Right knee
( ) Right shoulder **( )** Right elbow **( )** Right hip **( )** Right ankle
( ) Other: _____

Windshield:

( ) Right side of the head **( )** Right arm **( )** Right wrist **( )** Right knee
( ) Right shoulder **( )** Right elbow **( )** Right hip **( )** Right ankle
( ) Other: _____

Steering Wheel:

( ) Right side of the head **( )** Right arm **( )** Right wrist **( )** Right knee
( ) Right shoulder **( )** Right elbow **( )** Right hip **( )** Right ankle
( ) Other: _____

Right Door:

( ) Right side of the head **( )** Right arm **( )** Right wrist **( )** Right knee
( ) Right shoulder **( )** Right elbow **( )** Right hip **( )** Right ankle
( ) Other: _____

Left Door:

( ) Left side of the head **( )** Left arm **( )** Left wrist **( )** Left knee
( ) Left shoulder **( )** Left elbow **( )** Left hip **( )** Left ankle
( ) Other: _____

Seat Frame:

( ) Right side of the head **( )** Right arm **( )** Right wrist **( )** Right knee
( ) Right shoulder **( )** Right elbow **( )** Right hip **( )** Right ankle
( ) Other: _____

Unknown Object:

( ) Right side of the head ( ) Right arm ( ) Right wrist ( ) Right knee
( ) Right shoulder ( ) Right elbow ( ) Right hip ( ) Right ankle
( ) Other: _____

PS All this information is critical to understanding the extent of your injuries so please leave as little information bank as possible.

Surgical History: ☐ Yes ☐ No ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Shoulder ☐ Knee Rt Lt

Other:_____

Illness: ☐ Diabetes ☐ Hypertension ☐ Myocardial Infarction ☐ COPD ☐ Stroke ☐ Cancer
☐ MS ☐ MI Other:_____

Family Medical History: ☐ Diabetes ☐ Hypertension ☐ Myocardial Infarction ☐ COPD
☐ Stroke ☐ Cancer ☐ MS ☐ Other:_____

Other symptoms or comments:

_____

_____

_____

_____

PATIENT'S SIGNATURE:_____