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: ____

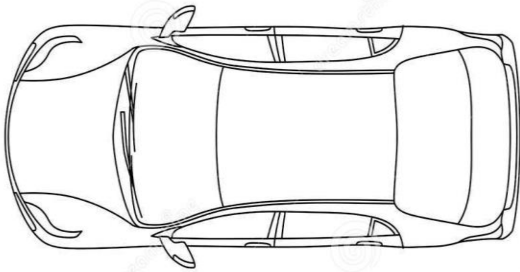
Other Party Insurance Company (If Applicable):
Name of Insurance Company: ___________________________________ Ins Phone #: _______________

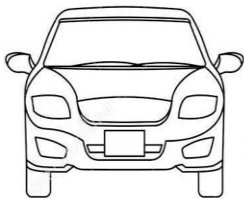
Secondary Claim #: ____

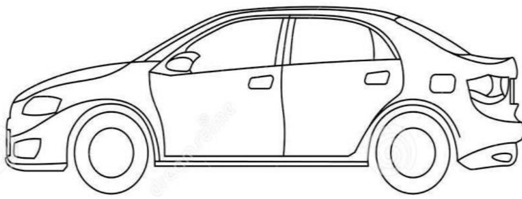
At Fault Party's Name: ____ Phone #: __________________

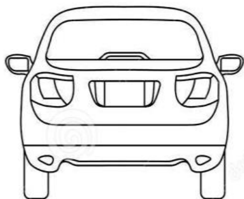
ACCIDENT HISTORY:

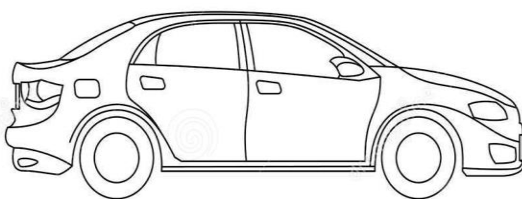
Date of Accident: _________________________ Time of Accident: _______________________ AM or PM











State how the accident happened in your own words:

____

____

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____

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____

← 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: ____

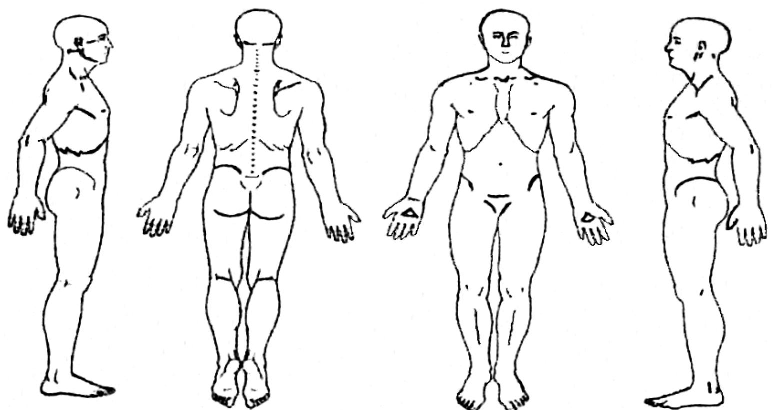
Condition #2: Second complaint: ____

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): ___________________

____

Patient Signature: ____ Date: ________________