

## 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):**

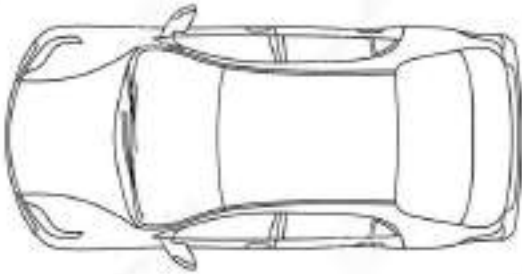
Name of Insurance Company: \_\_\_\_\_ Ins Phone #: \_\_\_\_\_

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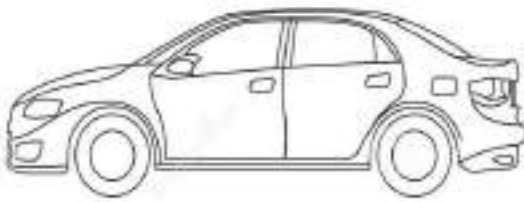
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← Please indicate where your car was damaged to the best of your ability.

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: \_\_\_\_\_

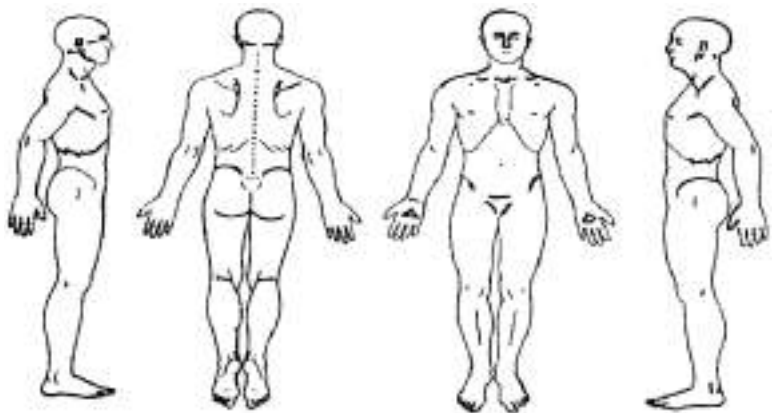
Condition #2: Second complaint: \_\_\_\_\_

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: \_\_\_\_\_