JESTER
FAMILY CHIROPRACTIC

Auto Collision Intake

Today's Date: _____
First Name: _____ M.I.: _____ Last Name: _____
Sex (M/F): _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____

Work Name: _____
Work Address: _____
City: _____ State: _____ Zip Code: _____
Work Phone: _____ Immediate Supervisor Name: _____
What type of work do you do: _____
Name of Spouse: _____ Phone #: _____
Nearest Relative: _____ Phone #: _____

History of Injury
Date and time Injury/collision (Required): Date: _____ Time: _____ AM or PM
In your own words, please describe the accident: _____
_____
_____
_____
_____
_____
_____
_____
In your own words at the time of the MVC (Motor vehicle collision)
Were you wearing your seat belt? __yes __no
Where the other passengers wearing their seat belts? ___yes ___no
Did the air bags deploy at the time of impact? ___yes ___no ___
Where both your hand on the steering wheel at time of impact? ___yes ___no
What position was your body and head in just prior to the accident? _____
What happened to your body at the time of impact? _____
How many people where in the accident? _____ Please give the names of any others in the accident: _____
_____
Were there any others injured in the accident (Yes/No)? _____ Where? _____
Were there any casualties in the accident (Yes/No)? _____
Were the police called (Yes/No)? _____ Was there a police report (Yes/No)? _____
Was anyone issued a citation at the scene (Yes/No)? _____ Who? _____
Were you prepared for the accident (Yes/No)? _____
___ I was completely surprised ___ I saw the object coming ___ I saw the object coming and braced appropriately
Did you receive medical attention at the scene of the accident (Yes/No)? _____ Who From? _____-
_____
Where did you go immediately after the accident (hospital, home, back to work, etc.)? _____
If you went to the hospital, which hospital did you go to? _____
Name of hospital doctor: _____
When did you go to the hospital? ___ immediately after ___ the next day ___ within a week ___ within a month

If you waited longer than a month to go to the hospital, what was your reason for waiting? _____
_____
How did you get there? ___ ambulance ___ drove my myself _____by someone else
What type of treatment did you receive? ___Xray ___MRI ___CT scan ____Pain medication ___ bandages ___ cast ___ neck brace ___ splints ___ collar ___ shot(s)___ antibiotics ___ ice pack ___ hot pack ___ surgery ___ crutches
Please give name(s) and reason for medication(s) or shot(s): _____
_____
Have you seen another healthcare provider since the collision (Yes/No)? _____ Who? _____
_____

Please describe how you felt mentally physically, and emotionally:
At the time of the collision: _____
Immediately after the collision: _____
Later that day: _____
The next day: _____
Presently: _____
Since the collision, have your symptoms: ___ improved ___ worsened ___ stayed the same

Please check/circle any symptoms you have noticed **since** the collision:

□ Headaches	□ Foot pain/numbness	□ Cold hands	□ Loss of taste
□ Neck pain	□ Head heaviness	□ Upset stomach	□ Loss of smell
□ Upper/mid back pain	□ Neck stiffness	□ Diarrhea	□ Anxiety
□ Lower back pain	□ Back stiffness	□ Constipation	□ Problems sleeping
□ Chest pain	□ Pins/needles in arms	□ Fainting	□ Tension
□ Arm pain/numbness	□ Pins/needles in hands	□ Blurred vision	□ Irritability
□ Hand pain/numbness	□ Pins/needles in legs	□ Buzzing/ringing in ears	□ Dizziness
□ Leg pain/numbness	□ Pins/needles in feet	□ Loss of balance	□ Nausea
□ Loss of appetite	□ memory loss		

Insurance Information

Patient's Auto Insurance:
Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____ Claim #: _____

Other Party's Auto Insurance:
Name: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Policy #: _____ Claim #: _____

Attorney Information:
Attorney Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Sign: _____ Date:_____