HANSEN CHIROPRACTIC WELLNESS CENTER

AUTO ACCIDENT INTAKE FORM

Last_____ First_____ Middle_____ Birthdate___/___/_____

Address_____ City_____ State_____ Zip_____

Phone Number (cell)_____ (home)_____ Today's Date ___/___/_____

Email_____ Occupation_____ Employer_____

Spouse's Name_____ Spouse's Phone Number_____

Who may we thank for referring you to our office? _____

Who is your primary care physician? _____ Phone Number_____

Date of last physical/exam: _____

Date of accident_____ Time of accident_____ am / pm ☐ **Daylight** ☐ **Dawn** ☐ **Dusk** ☐ **Dark**

Road conditions at the time of accident ☐ **Wet** ☐ **Dry** ☐ **Snow** ☐ **Ice** ☐ **Other**_____

Was this accident on the job? ☐ **Yes** ☐ **No** If yes, were you in a company vehicle? ☐ **Yes** ☐ **No**

Where were you seated in the vehicle? ☐ **Driver** ☐ **Passenger** ☐ **Rear-seat** ☐ **Other**_____

Were you aware of the approaching collision prior to impact or were you surprised? ☐ **Aware** ☐ **Surprised**

Did you lose consciousness upon impact? ☐ **Yes** ☐ **No**

Did you experience a flash of light or an 'explosion' in your head? ☐ **Yes** ☐ **No**

Did the police come to the scene of the accident? ☐ **Yes** ☐ **No** If yes, was there a report written? ☐ **Yes** ☐ **No**

Were you wearing a seatbelt? ☐ **Yes** ☐ **No** If yes, did you receive any injury or bruising from the seatbelt? ☐ **Yes** ☐ **No**

Did your head hit the headrest during the accident? ☐ **Yes** ☐ **No**

Was the position of the headrest altered? ☐ **Yes** ☐ **No**

Was the seat adjustment altered by the accident? ☐ **Yes** ☐ **No**

Was the seat broken by the accident? ☐ **Yes** ☐ **No**

Did the airbag deploy? ☐ **Yes** ☐ **No** If yes, did it strike you? ☐ **Yes** ☐ **No** If yes, where? _____

Which way was your head pointing at the time of impact? ☐ **Straight** ☐ **Down** ☐ **Right** ☐ **Left**

Which way was your body pointing at the time of impact? ☐ **Straight** ☐ **Right** ☐ **Left**

Where were your hands? ☐ **One on the wheel** ☐ **Both on the wheel** ☐ **Other** _____

Were you wearing a hat or glasses at the time of impact? ☐ **Yes** ☐ **No** If yes, were they still on after impact? ☐ **Yes** ☐ **No**

Did you go to the hospital? ☐ **Yes** ☐ **No** If yes, when? ☐ **Immediately** ☐ **___hours later** ☐ **___days later**

Which hospital? _____

How did you get to the hospital? _____ How long did you stay at the hospital? _____

Continued on next page…

What did the hospital do for your injuries? (collars, splints, x-rays, medication, surgery, etc.) _____

_____

What areas were x-rayed? _____ What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? ☐ **Yes** ☐ **No** If yes, please complete information below:

Dr. _____ Specialty:_____ Date first seen:_____

Type of treatment:_____ Treatment frequency:_____

Are you still receiving treatment? _____

YOUR VEHICLE

Please list the year, make, and model of the car you were in: **Year**_____ **Make**_____ **Model**_____

Was your car stopped at the time of impact? ☐ **Yes** ☐ **No**

If yes, was the driver's foot on the brake? ☐ **Yes** ☐ **No** If no, estimate the speed of the vehicle you were in: _____ mph

If your vehicle was moving at the time of impact, was it: ☐ **Slowing down** ☐ **Gaining speed** ☐ **Steady speed**

OTHER VEHICLE

Please list the year, make, and model of the other car: **Year**_____ **Make**_____ **Model**_____

Was the other vehicle moving at the time of impact? ☐ **Yes** ☐ **No**

If yes, what was the approximate sped of the vehicle: _____ mph

At the time of impact, the other car was: ☐ **Slowing down** ☐ **Gaining speed** ☐ **Steady speed**

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in: _____

Name of their auto insurance: _____

Policy #: _____ Claim #: _____

Auto insurance phone number: _____ Name of insurance adjuster: _____

Driver of the ***other*** automobile: _____

Name of their auto insurance: _____

Policy #: _____ Claim #: _____

Auto insurance phone number: _____ Name of insurance adjuster: _____

Have you retained an attorney? ☐ **Yes** ☐ **No**

If yes, what is their name and phone number? _____

LIFESTYLE INFORMATION

Do you smoke? ☐ **Yes** ☐ **No** If yes, how many packs per week? _____

Continued on next page…

Do you consume alcohol? ☐ **Yes** ☐ **No** If yes, how many drinks per week? _____

Do you consume caffeine? ☐ **Yes** ☐ **No** If yes, how many drinks per day? _____

Do you exercise? ☐ **Yes** ☐ **No** If yes, how many times per week? _____ What type? _____

Do you have a high stress level? ☐ **Yes** ☐ **No** If yes, please list reasons: _____

Please list any medications, vitamins, or supplements you are currently taking:

Name:_____ Frequency:_____ Dosage:_____ What is this for?_____

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Name:_____ Frequency:_____ Dosage:_____ What is this for?_____

OCCUPATIONAL INFORMATION

Job involves: ☐ **Sitting** ☐ **Standing** How long? _____ ☐ **Lifting** How much? _____ lbs.

☐ **Bending** ☐ **Twisting** ☐ **Turning** ☐ **Stooping**

Physical activity at work: ☐ **Sedentary** ☐ **Light, manual labor** ☐ **Manual labor** ☐ **Intense, manual labor**

Have you missed any time from work due to the accident? ☐ **Yes** ☐ **No** If yes, how many days? _____

Dates of work missed: _____

Are your work activities restricted because of the accident? ☐ **Yes** ☐ **No** If yes, please explain: _____

_____

Do any of your work activities aggravate your current complaints? ☐ **Yes** ☐ **No** If yes, please explain: _____

_____

CURRENT COMPLAINTS

Check any of the symptoms below you have noticed since the accident:

- ☐ Headaches/Migraines
- ☐ Neck Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Shoulder Pain
- ☐ Depression
- ☐ Buzzing in Ears
- ☐ Arm/Leg Pain
- ☐ Jaw Pain/Clicking
- ☐ Dizziness
- ☐ Fatigue
- ☐ Loss of Memory
- ☐ Cold Hands/Feet
- ☐ Numbness/Tingling
- ☐ Loss of Smell
- ☐ Irritability
- ☐ Digestive Problems
- ☐ Joint Pain/Stiffness
- ☐ Menstrual Problems
- ☐ Pinched Nerve
- ☐ Loss of Sleep
- ☐ Loss of Balance
- ☐ Chest Pain
- ☐ Sensitivity to Light
- ☐ Fever
- ☐ Nervousness
- ☐ Other: _____
- ☐ Vision Problems
- ☐ Urinary Problems
- ☐ Sleeping Problems
- ☐ Paralysis
- ☐ Tension
- ☐ Fainting
- ☐ Pins/Needles Feeling
- ☐ Upset Stomach
- ☐ Difficulty Swallowing
- ☐ Sciatica
- ☐ Sinus Pain
- ☐ Sore Muscles
- ☐ Head Feels Too Heavy

At the time of the accident, did you become or experience any of the following?

- ☐ Disoriented
- ☐ Dizzy
- ☐ Confused
- ☐ Nauseated

Continued on next page…

☐ Blurred Vision ☐ Lightheaded
☐ Loss of Balance ☐ Ringing/Buzzing in Ears

Do you still have any of these symptoms? ☐ **Yes** ☐ **No** If yes, which ones? _____

_____

SPECIFIC AREAS OF COMPLAINT

1. Body Part: _____

   Date symptom first appeared: _____

   How often do you experience these symptoms?

   ☐ **Constant** 100% ☐ **Frequent** 75% ☐ **Intermittent** 50% ☐ **Occasional** 25% ☐ **Rare** 10%

   What makes these symptoms increase? _____

   What makes these symptoms decrease? _____

   Types of pain? ☐ **Sharp** ☐ **Dull** ☐ **Aching** ☐ **Burning** ☐ **Throbbing** ☐ **Numbness**

   ☐ **Other:**_____

   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme)

   0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

   If the pain radiates, where does it radiate to? _____

2. Body Part: _____

   Date symptom first appeared: _____

   How often do you experience these symptoms?

   ☐ **Constant** 100% ☐ **Frequent** 75% ☐ **Intermittent** 50% ☐ **Occasional** 25% ☐ **Rare** 10%

   What makes these symptoms increase? _____

   What makes these symptoms decrease? _____

   Types of pain? ☐ **Sharp** ☐ **Dull** ☐ **Aching** ☐ **Burning** ☐ **Throbbing** ☐ **Numbness**

   ☐ **Other:**_____

   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme)

   0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

   If the pain radiates, where does it radiate to? _____

3. Body Part: _____

   Date symptom first appeared: _____

   How often do you experience these symptoms?

   ☐ **Constant** 100% ☐ **Frequent** 75% ☐ **Intermittent** 50% ☐ **Occasional** 25% ☐ **Rare** 10%

   What makes these symptoms increase? _____

   What makes these symptoms decrease? _____

   Types of pain? ☐ **Sharp** ☐ **Dull** ☐ **Aching** ☐ **Burning** ☐ **Throbbing** ☐ **Numbness**

   ☐ **Other:**_____

   Please rate the intensity of your symptoms (0 being no pain, 10 being extreme)

   0 ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ◆ 6 ◆ 7 ◆ 8 ◆ 9 ◆ 10

   If the pain radiates, where does it radiate to? _____

Continued on next page…

Other body parts affected (shoulders, knees, head, wrists, etc.)? _____

Any other additional information: _____

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

_____ Patient Signature _____ Date