Automobile Accident Intake Form

NORTHLAKE CHIROPRACTIC

Today's Date:_____ Referred by:_____

Last Name:_____ First Name:_____ SSN:_____

Address:_____ DOB:_____

City:_____ State:_____ Zip:_____ Gender: M or F

Home Phone:_____ Cell Phone:_____ Email:_____

Occupation:_____Employer:_____Work Phone:_____

Marital Status:_____ Spouses Name:_____ Spouse's Employer:_____

Emergency Contact:_____ Phone:_____

INSURANCE INFO: Have you retained an attorney? Yes No Name _____Phone Number _____

Their (the responsible parties) Insurance Company:_____

Claims Address:_____ Phone #:_____

Effective Date:_____ Policy #:_____ Group #:_____

Vehicle Driver:_____ Claim #:_____

Your Insurance Company:_____

Claims Address:_____ Phone #:_____

Effective Date:_____ Policy #:_____ Group #:_____

Relationship to Insured:_____ Claim #:_____

REASON FOR TODAY'S VISIT / ACCIDENT DETAILS: Time and date of accident_____ AM/PM ____/____/____

Please explain in detail how the accident occurred:_____

What direction were you heading?_____ The other vehicle?_____

Did you strike the windshield or other object? Yes No Did you lose consciousness: Yes No If so, how long? _____

Were you struck from? Front Behind Left Side Right Side Were you wearing a seat belt? Yes No

Number of people in the car _____ Your position in the car _____

Did you go to the hospital after the accident? Yes No What treatment did you receive? _____

If so, give doctor's name _____ Phone Number _____ Doctor's diagnosis_____

Did you feel pain immediately after the accident? Yes No ___ Later that day ___ Next day When?_____

What were the symptoms you experienced? _____

Did you ever have complaints in the involved area before? Yes No If so, when? _____

Before the injury, were you capable of working on an equal basis with others your age? Yes No

Are your work activities or activities of daily living restricted as a result of this accident? Yes No If so, how?

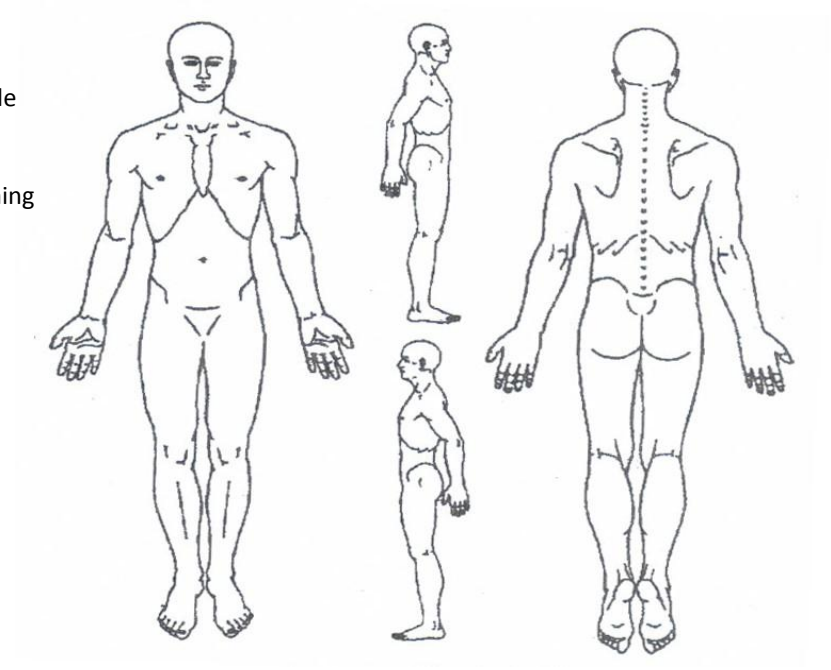
_____

AREAS OF INJURY OR DISCOMFORT:

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

What aggravates your condition(s): (Circle) Standing Twisting Bending Sitting Lying Walking Coughing Lifting

By using the key below, indicate on the body diagram where you are experiencing the following symptoms: (Mark all the areas with the appropriate symbols, circle an area of pain not represented by a symbol).



N = Numbness A = Aching B = Burning
P = Pins & Needles S = Stabbing

Are your symptoms: ____ Improving
____ About the same
____ Getting worse

How often do you experience your symptoms?

Constantly (76-100% of the day)
Frequently (51-75% of the day)
Occasionally (26-50% of the day)
Intermittently (0-25% of the day)

Have you had these symptoms before? Yes No

HEALTH HISTORY

Major surgeries:_____
Hospitalizations:_____
Accidents or falls:_____
List all prescriptions you now take:_____
List all NON-prescription drugs you now take:_____
List anything you are allergic to:_____
Do you use tobacco (cigarettes/chew): Yes No If so, how much?_____ How long?_____
Do you drink alcohol: Yes No If so, how much? _____ How often?_____
Do you use recreational drugs: Yes No If so, which ones?_____ How often:_____
Do you exercise: Yes No If so, how many hours per week?_____
Do you currently wear: Shoe lifts Inner soles Arch supports

For Women: Are you pregnant? Yes No If so, how many weeks?_____ Are you nursing? Yes No

Please check any of the following that you currently have or have had in the past:

__ Headaches	__ Bronchitis	__ Hiatal hernia	__ Thyroid problems
__ Sinus/Allergies	__ Pulmonary disease	__ Premenstrual Pains	__ Fatigue
__ Asthma	__ Emphysema	__ Joint pain	__ Depression/Psychiatric Illness
__ Arthritis	__ Pneumonia	__ Jaw pain	__ Chest Pains
__ Sciatica/Buttock pain	__ Kidney stones	__ Shoulder pain	__ Stomach Problems
__ Heart Disease	__ Gastric Ulcers	__ Numbness	__ High blood pressure/hypertension
__ Heart Murmurs	__ Colitis/Spastic Colon	__Hepatitis A, B, C	__ Low blood pressure/hypotension
__ Diabetes	__ Acid reflux	__ HIV/AIDS	__ Dizziness
__ Stroke	__ ADD/ADHD	__ Fractures	__ Skin problems
__ Cancer	__ Difficult/painful urination		

I hereby authorize the doctor(s) and the staff of Northlake Chiropractic to administer any treatments and testing necessary for the purpose of improving my physical condition. The above patient information is true and accurate to the best of my knowledge.

_____ _____ _____
Patient Signature (custodial parent or legal guardian if patient is a minor) Relationship to patient Date