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Motor Vehicle Collision Intake Form

Name ____ **DOB** _______________ **Date** ________________

Male _____ Female ____ Height ____________ Weight __________ Single ______ Married ________

Address _____________________________ City ______________________ State ____ Zip_________________

Home Phone _____________________________ Email address ____

Cell Phone _______________________________ Cell Carrier for text reminders ______________________________

Insurance Company_______________________________________ Claim #_________________________________

Claims Adjuster_______________________________________ Phone Number_______________________________

Attorney's Name______________________________________ Phone Number _______________________________

Employer ____ Occupation __________________________________

Days missed from work since Accident ________________________________

Date of Accident ___________________ Time of Accident ________________

City and state of Accident _____________________________ Street Names _________________________________

Description of Accident ____

____

____

____

#1) Your vehicle's year, make, model ____

Were you the driver, front passenger, rear passenger, etc.? ____

Was your vehicle: stopped, accelerating or decelerating?

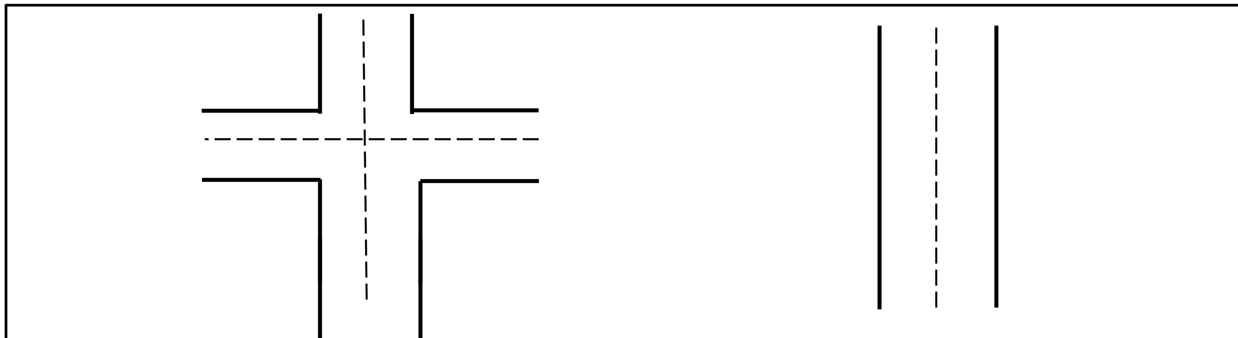
Type of accident: rear-ended, frontal collision, side-impact, other? ____

#2) Other vehicle's year, make, model ____

Road conditions during accident: dry, wet, rain, snow, other? ____

Was the other vehicle: stopped, accelerating, decelerating?

Please draw the accident using #1 for your vehicle and #2 for the second vehicle



Patient Name: ______________________________ **DOB** ________________

What position was your headrest in: fixed, lowest, middle, highest?

Did you use a: shoulder and lap belt, lap belt only, no seatbelt, car seat, booster?

At the time of impact was your head facing: forward, left, right, up, down?

At the time of impact was your torso facing: forward, left, right, leaning back?

Did your airbag deploy during the accident? Yes No

Was your seat back broken? Yes No Did you brace for impact? Yes No

Were your hands on the steering wheel at the time of impact? Yes No

If yes, which hand(s): both, right only, left only

Was your foot on the brake pedal at the time of impact? Yes No

Did the collision move your vehicle? Yes No Which direction? ______________________________

Did anything in the vehicle move due to the impact (purse, phone, wallet, etc.)? ______________________

Did any part of your body strike the inside of the vehicle? Yes No

If yes, explain: ____

Did you lose consciousness after the collision? Yes No For how long? ____________________

Describe the damage to your vehicle: ____

How much did the auto body shop estimate the damage to be? ______________________________

Describe the damage to the other vehicle: ____________________________________

Did the police respond to the scene? Yes No Did you file a DMV accident report? Yes No

Did an ambulance respond to the scene? Yes No

Did you go to a hospital? ____

What tests did they do? ________________________ Diagnosis? ______________________

What medications were prescribed? ____

Where did you go following the collision? __________________________________

How did you get there? ____

My pain started: immediately, slowly over time, quickly after injury

My pain is: constant, comes and goes, depends on activity My condition is getting: better, worse, same

My pain feels: sharp, tight, dull ache, numb, burning, throbbing, stabbing, tingling

My pain increases when I: sit, stand, stand up, bend, walk, reach, climb stairs, lift, get in and out of a car

What makes your pain better: ice, heat, bed rest, wraps or braces, traction, Aspirin, Tylenol, Advil, Naproxen, stretching, other ____

My pain interferes with: work, sleep, daily routine, recreation

Did you have any cuts or bruises from the accident? Yes No

If yes, explain: ____

Have you had a similar condition in the past? Yes No

If yes, explain: ____

Patient Name: ____________________________________ **DOB ___________________**

What other health provider have you seen for this condition? ____

What other tests have you had done for this condition: X-rays, CT/ MRI, Ultrasound, blood tests, urinalysis

What other treatment have you had for this condition? ____

Surgeries / year ____

Fractures / year ____

Auto Accidents / year ____

Do you smoke? never smoker, former smoker, current daily smoker, sometimes smoker

Do you drink alcohol? None, rarely, occasionally, weekly, daily

Do you exercise? Y / N How often? ___________ What kind of exercise? ______________________________

Are you a pregnant woman? Y / N What month? ___________ Ages of other children ________________________

List all medications you are currently taking and the dosages, including prescriptions, vitamins, etc.

____

____

Allergies? ____

Please circle any cognitive symptoms since the accident:

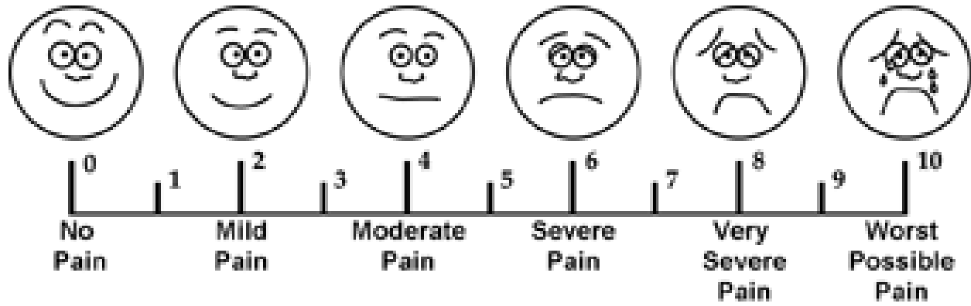
Headaches, nausea, vomiting, balance problems, dizziness, visual problems, fatigue, sensitivity to light, sensitivity to sounds, numbness/tingling, feeling mentally foggy, feeling slowed down, difficulty concentrating, difficulty remembering, irritability, sadness, more emotional, nervousness, drowsiness, sleeping less than usual, sleeping more than usual, trouble falling asleep

Does anyone in your immediate family have the following illnesses? If yes, please list relationship.

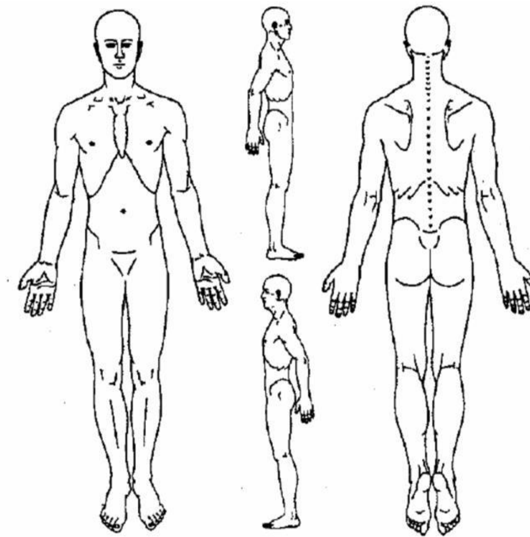
	Yes	No	Grandmother	Grandfather	Mother	Father	Sister	Brother
Arthritis								
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Multiple Sclerosis								
Stroke								

Patient Name: ___________________________________ **DOB __________________**

Please circle the face below to show how bad your pain has been recently:



Please circle your areas of pain:



Please present your current insurance card and photo ID to the receptionist.