CLEAR CHOICE CHIROPRACTIC
AUTO ACCIDENT INTAKE

PATIENT INFORMATION Today's Date: _____/_____/______

First __________________ MI _____ Last _______________

Address __________________________________ Apt _____

City __________________________ State ____ Zip________

Birth Date ______/_______/_______ Age _____ Gender M F

AUTO INSURANCE INFORMATION

Company: _________________________________

Policy # _________________________________

Claim # __________________________________

Claim Rep: ________________________________

Phone: ( ) ________ - ________ Ext: ______

OTHER DRIVER'S AUTO INSURANCE

Company: ________________________________

Policy # _________________________________

Claim # __________________________________

Claim Rep: ________________________________

Phone: ( ) _______ - _______ Ext: ______

ATTORNEY INFORMATION

Have you contacted an attorney? Yes No

Attorney:___________________________________

Phone: ( ) ________ - ________ Ext: ______

DESCRIPTION OF AUTO ACCIDENT/INJURY

Date of Accident: ____/____/____ Time of Accident: ____:____ am pm In what State? OR WA CA

Name of street/location on which you were traveling?____

Describe the accident:

____

____

____

How many vehicles were involved? _________

Make & Model of the vehicle you were occupying: ____

Were you: Driver Front Passenger Rear Passenger-L/R Other_________

What damage did this vehicle sustain? Minimal Moderate Extensive Unsure

How many people were in the vehicle? ______

What did your vehicle impact? Another vehicle Other __________________

Were you struck from: Behind Head on Passenger side Driver's side

Estimated speed of impact? _________ mph

Make & Model of the vehicle that struck you: ____

What damage did this vehicle sustain? Minimal Moderate Extensive Unsure

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How fast was the other vehicle driving? _________mph
Were there other vehicles involved? □ Yes □ No If YES, describe vehicle type and how it stuck.
____

What time of day did the accident occur? □ Daylight □ Dawn □ Dusk □ Night □ Other

What was the condition of the road? □ Dry □ Damp □ Wet □ Snow/Ice □ Other

What was the visibility at the time of impact? □ Good □ Fair □ Poor □ Other

If visibility was poor, why? □ Sunlight □ Darkness □ Rain □ Fog □ Snow □ Traffic

Were you prepared for the accident? □ Aware □ Braced for impact □ Unaware/Surprised

Was the vehicle equipped with air bags? □ Yes □ No If YES, did they deploy? □ Yes □ No

Were you wearing a seatbelt? □ Yes □ No

What position was the headrest in? □ Low □ Middle □ High □ Unsure

Did any part of your body strike anything in the vehicle? Please describe ___________________________
____

What direction was your body positioned at the time of impact?
□ Straight □ Slouched forward □ Rotated to Left □ Rotated to Right □ Unsure

Were the police called? □ Yes □ No
Was a police report filed? □ Yes □ No □ Unsure
Were any citations issued? □ Yes □ No □ Unsure

DETAILS OF ACCIDENT/INJURY

Were you knocked unconscious? □ Yes □ No

How did you feel immediately after the accident?
□ Confused □ Dazed □ Dizzy □ Nervous □ Weak □ Other

Where did you develop pain? □ Head □ Neck □ Upper/Mid Back □ Lower Back □ Pelvis □ Hips
□ Chest/Rib Cage □ Abdomen □ Shoulders □ Arms/Elbow □ Hands/Wrists □ Buttocks
□ Thighs □ Knees □ Legs □ Feet/Ankles

When did you develop the pain? □ Immediately □ Gradual

Did you go to the hospital or were you seen by any other doctor? □ Yes □ No
If YES, provide the hospital or doctor name ____

When did you go? □ Just after □ next day □ 2 days + □ Other _________________

How did you get there? □ Myself □ Friend □ Family □ Ambulance □ Other

Were X-Rays taken? □ Yes □ No
Where?________________________________ What body part(s)? ____________________________

Were Medications prescribed? □ Yes □ No If Yes, what? ____________________________________

FOLLOWING THE ACCIDENT/INJURY

How much later did additional symptoms develop?
□ Immediately □ Hours □ That Evening □ Next Morn □ Days □ Week □ Month

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What additional symptoms did you developed?

 Head Jaw Neck Upper/Mid Back Low Back Pelvis Hips
 Chest/Ribs Abdomen Shoulders Arms/Elbows Hands/Wrists
 Buttocks Thighs Knees Legs Feet/Ankles

What type of pain would you describe it as?

 Pain Stiffness Numbness Tingling Other ______________________________

Since the accident/injury, have you suffered from?

 Impaired Vision Impaired Hearing Ringing in Ears Chest Pain
 Difficulty Breathing Palpitations Nausea Vomiting

Additionally, have you experienced any of the following?

 Anxiety Depression Mood Swings Nervousness Poor Memory
 Tension Convulsions Dizziness Headaches Fainting Fatigue
 Loss of Balance Restlessness Insomnia Light Sensitivity Weakness
 Reduced Appetite Weight Gain Weight Loss

Are you restricted in any of the following areas as a result of the accident/injury?

 Daily Living Occupational/Work Recreational Activities Other ________

Have you missed work due to this accident/injury? Yes No

From:_____________ To:_____________

Did you self-treat your symptoms?

 Ice Heat Bed Rest Over the Counter Meds Other __________

****

I have answered the questions to the best of my knowledge.

Print Name: ____

Patient/Guardian Signature: ______________________________________**Date:** _____/_____/_____

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