Great Lakes Chiropractic
116 Central Ave East St. Michael, MN 55376
PH: 763-515-6650 | FAX: 763-777-9186

Existing Patient Motor Vehicle Accident Intake

TODAY'S DATE:	DATE OF BIRTH:
NAME:	
INSURANCE COMPANY:	
ADJUSTER NAME:	
ADJUSTER PHONE NUMBER:	
POLICY ID:	
CLAIM NUMBER:	

*Office Use Only: Last DOS*______________________

1. Date of accident: _____/_______/_______

2. Time of accident: _____________AM / PM

3. How many vehicles were involved in the accident? ____

4. What was the estimated damage to the vehicle you were in? ____

5. What state did the accident occur in? ____

6. What city did the accident occur in? ____

7. What street or intersection were you on when the accident occurred?

____

8. What direction were you traveling in? (check) North___ South___ East ___ West___

9. What type of impact was the auto accident? (i.e. rear ended / head on)

____

10. Did your vehicle hit anything after the accident? If yes, please describe:

____

11. Where were you sitting in the vehicle?
Please circle: Driving / Front passenger / Back seat on driver side / Back seat on passenger side

12. Did you know the accident was coming? Yes ___ No ___

13. What type of vehicle were you in? (Make/Model) ____

14. What type of vehicle impacted yours? (Make/Model) ____

15. At the time of the impact, how fast was your vehicle moving? ____

16. At the time of impact, how fast was the other vehicle moving? ____

17. During and after the crash what happened to your vehicle? (check all that apply)

___ kept going straight
___ kept going straight hitting a car in front
___ was hit by another vehicle
___ spun around and hit a stationary object
___ hit a stationary object
___ spun around

___ other: Details____

18. Did you lose consciousness during the accident? Yes ___ No ___

19. How was your head positioned during the accident? ____

20. How was your torso positioned during the accident? ____

21. How were your hands positioned during the accident? ____

22. Did your head hit anything during the accident? No ___ Yes, please describe: ___________________________

____

23. Did your face hit anything during the accident? No ___ Yes, please describe___________________________

____

24. Did your shoulders hit anything during the accident? No ___ Yes, please describe___________________________

____

25. Did your neck hit anything during the accident? No ___ Yes, please describe: ___________________________

____

26. Did your chest hit anything during the accident? No ___ Yes, please describe: ___________________________

____

27. Did your hips hit anything during the accident? No ___ Yes, please describe: ______________________________

____

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28. Did your knees hit anything during the accident? No ___ Yes, please describe: ________________________________

____

29. Did your feet hit anything during the accident? No ___ Yes, please describe: _________________________________

____

30. What kind of headrest was in your vehicle? (check one)

___ movable fixed headrest ___ fixed non-movable headrest ___ no headrest

31. Did you have your seatbelt on during the accident? Yes ___ No ___

32. Did you slide out of your seatbelt during the accident? Yes ___No ___

33. What was damaged in your vehicle? (Check all that apply)

___ windshield ___ rear bumper ___ mirror
___ steering wheel ___ front bumper ___ knee bolster
___ dashboard ___ trunk ___ back right door
___ rear window ___ front left door ___ back left door
___ side window ___ front right door ___ seat frame
___ entire vehicle totaled ___ other: ____

34. Choose the items that dented inward:

___ floorboards ___ side door ___ dashboard ___ none

35. Choose the doors that would not open as a result of the accident:

___ front left ___ front right ___ rear left ___rear right

36. Did you go to the hospital? Yes ___ No ___

37. How did you get to the hospital? ____

38. What was the name of the hospital? ____

39. Were you hospitalized overnight? ____

40. What you were prescribed at the hospital?

___ pain medication ___ muscle relaxers ___ brace ___ other: ______________________________________

41. Please list any other medications you are taking with dose/frequency.

____

____

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42. Did you receive any stitches for any cuts at the hospital? Yes ___ No ___

If yes, which area of the body? ____

43. Were x-rays taken at the hospital? Yes ___ No___ If yes, which area of the body____________________________

44. Was an MRI or other study performed? Yes ___ No ___ If yes, which area of the body _________________________

45. Please list facility where images were taken, if applicable ____

46. What is injured from your accident/incident? ____

____

47. Where does it hurt? Left? Right? Both sides?____

48. How would you describe your problem? Please circle all that apply.

Sharp	Shooting	Burning	Numb	Tingly
Dull	Achy	Sharp with Motion	Shooting with Motion	Stabbing with Motion

Other:____

49. How often do you have this problem? Please check ✓

Constantly (75-100% of the time)	Frequently (50-75% of the time)	Occasionally (25-50% of the time)	Intermittently (less than 25% of the time)

50. How would you rate the severity of your problem?

Mild	Moderate	Severe

51. Does your pain radiate anywhere in your body? If yes, please describe

____

52. Do you have pain at night? If yes, please describe

____

53. What makes your problem worse? Please circle all that apply.

Always there	Gardening	Shoveling	Standing up	Yard Work
Bending	Working Out	Sitting	Standing (long time)	Weather Changes
Driving	Lifting Objects	Sleeping	Stress	While at Work
Flexing/extending	Painting	Climbing Stairs	Computer Work	Sports:

Other, describe____

54. What makes your problem better? Please circle all that apply.

Adjustments	Heat	Ibuprofen	Standing	Warm Bath
Bending Forward	Ice	Tylenol	Stretching	Nothing
Exercising	Massage	Rx Pain Medication	TENS/Muscle Stim	
Pain Relieving Cream	Muscle Relaxer	Resting	Walking	

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55. Who have you seen for this problem? Please circle all that apply.

Chiropractor	ER Doctor	Massage Therapist	Physical Therapist
Neurologist	Orthopedist	Primary Care Doctor	No One

56. When and Where? ____

Other____

For each of the conditions listed below, place a ✓ in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a ✓ in the "present" column.

PAST	PRESENT	SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT	SYMPTOM
		Headache			Rheumatoid Arthritis			Gallbladder disorder
		Neck pain			Cancer			Hepatitis
		Upper back pain			Benign tumor			Ulcer
		Mid back pain			Asthma			General fatigue
		Low back pain			Chronic Sinusitis			Visual disturbances
		Shoulder pain			High blood pressure			Dizziness
		Elbow/upper arm pain			Heart attack			Ringing in the ears
		Wrist pain			Chest pains			Diabetes
		Hip pain			Kidney stones			Frequent urination
		Upper leg pain			Kidney disorder			Drug dependence
		Knee pain			Bladder infection			Alcohol dependence
		Ankle/foot pain			Prostate problems			Depression
		Jaw pain			Weight gain/loss			Anxiety
		Joint pain/stiffness			Abdominal pain			Lupus
		Arthritis			Liver disorder			Epilepsy/seizures
		Loss of Sleep			Heartburn			Eczema/rash

Patient's Signature: ____ **Date:** _________________

Guardian's Signature Authorizing Care: ____________________________________ **Date:** _________________

Doctor's Signature: ____ **Date:** _________________