



Personal Injury Intake

Patient Name: _____ Today's Date: _____

- 1) Date of **M**otor **V**ehicle **A**ccident (MVA): _____ Time: _____
- 2) Number of Vehicles involved in MVA: _____
- 3) Vehicle was: Totaled Damage to vehicle unknown
- 4) Please estimate the damage to your vehicle: \$ _____
- 5) What road did the MVA occur on? _____
- 6) What direction were you traveling in: NW N NE W E SW S SE
- 7) What city and state did the MVA occur? _____
- 8) Please choose the primary type of impact:
My vehicle:
 was rear ended
 hit another vehicle from behind
 was hit on the driver's side
 was hit on the passengers side
 other: _____
 Not Applicable
- 9) What did your vehicle do immediately after the accident?
 Hit a guardrail
 Hit a tree
 Rolled over
 Was run off of the road
 Other: _____
 Not Applicable
- 10) Where were you sitting in your vehicle?
 Driver
 Front passenger
 Rear left passenger
 Rear right passenger
 Rear passenger
 Other: _____
 Not Applicable
- 11) Prior to impact, were you:
 Unaware of the impending collision
 Aware of the collision and relaxed
 Aware of the impending collision and braced yourself

12) What type of vehicle were you in during the MVA?

- Subcompact car
- Compact car
- Mid-size car
- Full-sized car
- Truck
- SUV
- Minivan
- Van
- Larger than one ton vehicle
- Other: _____

13) Using the choices above, what type of vehicle impacted your vehicle? _____

14) At the time of impact, was your vehicle:

- Slowing down
- Stopped
- Gaining speed
- Moving at a steady speed
- Other: _____
- Not Applicable

15) In MPH, what is your estimate for how fast the other vehicle was moving? _____

16) At the time of impact, was the other vehicle:

- Slowing down
- Stopped
- Gaining speed
- Moving at a steady speed
- Other: _____
- Not Applicable

17) During and after the impact, what happened to your vehicle?

- Kept going straight
- Kept going straight hitting the car in front of me
- Was hit by another vehicle
- Spun around
- Spun around and hit a stationary object
- Hit a stationary object
- Other: _____
- Not Applicable

18) During the accident, did you:

- lose consciousness
- remain conscious throughout the entire MVA
- other: _____
- not applicable

19) How was your head positioned during the MVA?

- | | | |
|--|---|---|
| <input type="checkbox"/> facing forward | <input type="checkbox"/> turned to the left | <input type="checkbox"/> turned to the right |
| <input type="checkbox"/> facing upward | <input type="checkbox"/> facing downward | <input type="checkbox"/> facing right & upward |
| <input type="checkbox"/> facing right & downward | <input type="checkbox"/> facing left & upward | <input type="checkbox"/> facing left & downward |
| <input type="checkbox"/> other: _____ | | <input type="checkbox"/> Not Applicable |

20) How was your torso positioned during the MVA?

- forward left right torso extended
 torso flexed flexed w/ right rotation extended with right rotation
 not applicable flexed w/ left rotation extended with left rotation
 other: _____

21) How were your hands positioned during the MVA?

- left on steering wheel right hand on steering wheel
 both hands on steering wheel left hand on dashboard right on dashboard
 both on dashboard on the seat in front of me resting along side
 on ceiling of vehicle not applicable
 other: _____

22) Did you hit any of the following? Check all that apply.

	<u>head</u>	<u>face</u>	<u>shoulders</u>	<u>neck</u>	<u>chest</u>	<u>hips</u>	<u>knees</u>	<u>feet</u>
Windshield	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steering wheel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Side door	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dashboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceiling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Car frame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another passenger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seat side window	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Other: _____
 Not Applicable

23) What kind of headrests were in your vehicle?

- Moveable, fixed head restraints
 Fixed, non-movable head restraints
 No head restraints
 Other: _____
 Not Applicable

24) Where was the headrest positioned on your head:

- top back middle height of back lower portion of back
 level of the back of neck level of my shoulder blades
 other: _____
 Not Applicable

25) Did you have your seatbelt on?

- I was:
 wearing a shoulder strap seat belt
 wearing a lap belt seat belt
 was in a baby car seat
 in a booster seat
 not wearing a seatbelt
 cannot remember
 other: _____
 not applicable

26) Did you slide out of your seatbelt? yes partially no

27) What was damaged in your vehicle:

- windshield steering wheel dashboard seat frame
- side window rear window mirror knee bolster
- rear bumper front bumper trunk front left door
- front right door back left door back right door nothing
- completely totaled
- other: _____

28) Choose the items that dented inward during the MVA:

- floor board side door dash board none other: _____

29) Choose the doors that would not open as a result:

- front left front right rear left rear right none other: _____

30) How did you get the hospital?

- ambulance helicopter police car
- drove self walking did not go to the hospital
- other: _____

31) What hospital did you go to? _____

32) Were you hospitalized overnight? yes no not applicable

33) Were you prescribed pain medication? yes no not applicable

34) Muscle relaxants? yes no not applicable

35) Did you receive stitches for any cuts? yes no not applicable

36) Did you receive any of the following?

- cervical collar back brace both neither
- not applicable other: _____

37) Were the following performed at the hospital? Please check all that apply.

	<u>x-rays</u>	<u>MRI</u>	<u>special imaging</u>
Skull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mid back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

38) Please check the location(s) of your problem(s):

The Chiropractic Assistant will get specific information upon intake.

- | | | | | |
|------------------------------------|---------------------------------------|--------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> headaches | <input type="checkbox"/> jaw | <input type="checkbox"/> neck | <input type="checkbox"/> upper back | <input type="checkbox"/> shoulder |
| <input type="checkbox"/> arm | <input type="checkbox"/> elbow | <input type="checkbox"/> wrist | <input type="checkbox"/> hand | <input type="checkbox"/> mid back |
| <input type="checkbox"/> low back | <input type="checkbox"/> hip | <input type="checkbox"/> legs | <input type="checkbox"/> knee | <input type="checkbox"/> ankle |
| <input type="checkbox"/> foot | <input type="checkbox"/> other: _____ | | | |