AUTO ACCIDENT INTAKE

RESULTS CHIROPRACTIC

Patient's Name: _____ DOI: _____

1. What was the date of the accident? _____

2. What time did the accident occur? _____

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? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? if yes, please describe _____

_____

_____

11. Where were you sitting in the vehicle during the accident? _____

12. Did you know the accident was coming? _____

13. What type of vehicle were you in? Year:_____ Type:_____ Model:_____

14. What type of vehicle impacted yours? Year:_____ Type:_____ 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? (Mark "X" all that apply)

- ☐ Kept going straight.
- ☐ Kept going straight hitting a car in front.
- ☐ Spun around.
- ☐ Spun around and hit a stationary object.
- ☐ Was hit by another vehicle.
- ☐ Hit a stationary object.

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? Yes_____ No_____

Please describe: _____

_____

23. Did your face hit anything during the accident? Yes_____ No_____

Please describe: _____

_____

24. Did your shoulders hit anything during the accident? Yes_____ No_____

Please describe: _____

_____

25. Did your neck hit anything during the accident? Yes_____ No_____

Please describe: _____

_____

26. Did your chest hit anything during the accident? Yes_____ No_____

Please describe: _____

_____

27. What is the estimated damage to your vehicle? _____

28. Is there any additional information you believe the doctor should know about you and/or this accident?

_____

_____

_____

_____

The answers I have given on this questionnaire are made truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____