

**CHIGHER HEALTH
CHIROPRACTIC
& SPORTS REHAB CENTER LLC**

AUTO ACCIDENT INTAKE

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Name _____ Date of Birth _____ Phone _____
Address _____ City _____ State _____ Zip _____
Employer's Name _____ Employer's Address _____
Your Ins. Co. _____ Policy # _____ Agent's Name _____
Driver/Other Vehicle _____ Ins. Co. _____ Policy # _____
Have you retained an attorney? () Yes () No Name _____
Were there any witnesses? () Yes () No Name(s) _____

Nature of Accident:

1. Date of Accident: _____ Time of Day _____
2. Were you: () Driver () Passenger () Front Seat () Back Seat
3. Number of people in your vehicle? _____ Other Vehicle? _____
4. What direction were you headed? () North () East () South () West
on (name of street) _____
5. What direction was the other vehicle headed? () North () East () South () West
on (name of street) _____
6. Were you struck from: () Behind () Front () Left side () Right side
7. Were you knocked unconscious? () Yes () No. If yes, for how long? _____
8. Were police notified? () Yes () No
9. In your own words, please describe accident: _____

10. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No
If yes, please describe in detail: _____

11. Please describe how you felt:
 - a. DURING the accident: _____
 - b. IMMEDIATELY AFTER the accident: _____
 - c. LATER THAT DAY _____
 - d. THE NEXT DAY: _____

12. What are your PRESENT complaints and symptoms? _____

13. Do you have any congenital (from birth) factors which relate to this problem?
() Yes () No. If yes, please describe: _____

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14. Do you have any previous illnesses which relate to this case? _____ () Yes () No
If yes, please describe: _____

15. Have you ever been involved in an accident before? () Yes () No. If yes, please describe, including date(s) and type(s) of accidents, as well as injuries received. _____

16. Where were you taken after the accident? _____

17. Have you ever been treated by another doctor since the accident? () Yes () No.
If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

18. Since this injury occurred, are your symptoms: () Improving () Getting Worse () Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | |

Symptoms Other Than Above _____

20. Have you lost time from work as a result of this accident? () Yes () No.

If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? () Yes () No.

If yes, please state type of compensation you are receiving? _____

21. Do you notice any activity restrictions as a result of this injury?() Yes () No.

If yes, please describe, in detail: _____

22. Other pertinent information: _____

SIGNATURE

DATE
