Umpqua Chiropractic

Auto Injury Intake Form

Patient Name: _____

Patient Date of Birth: _____ Today's Date: _____

Date and Time of Accident: _____

Employer: _____

What is your current employment status?

- ☐ I resumed my same job and duties
- ☐ I resumed my same job with lighter duties
- ☐ I resumed alternate duties in the same industry
- ☐ I changed industry
- ☐ I have not resumed work

What kind of work is involved at your place of employment?

- ☐ Office and clerical
- ☐ Light labor
- ☐ Moderate labor
- ☐ Heavy labor

Were you a driver or passenger?

- ☐ Driver
- ☐ Passenger – circle one: Front Seat Left Rear Seat Right Rear Seat
- ☐ Motorcycle Rider
- ☐ Motorcycle Passenger
- ☐ On a bicycle
- ☐ Pedestrian

What was the year, make, and model of the vehicle you were in?

_____

Was your vehicle moving or stopped?

☐ Proceeding Along ☐ Stopped ☐ Stopped at Intersection ☐ Making a Right Turn

☐ Stopped in Traffic ☐ Making a Left Turn ☐ Slowing Down ☐ Stopped at Light

☐ Stopped at a Stop Sign ☐ Parking ☐ Accelerating

Patient Name:_____

What was the estimated speed of your vehicle? _____mph

What part of your vehicle did the other car hit?

☐ Rear ☐ Front ☐ Left Front ☐ Right Front ☐ Right Rear

☐ Front Passenger Side ☐ Door Back Passenger Side ☐ Door Front Driver Side Door

☐ Rear Driver Side Door

What was the make and model of the vehicle that hit you? _____

What was the estimated speed of the other vehicle? _____mph

What was the size of the vehicle that struck you?

☐ Same size as ☐ 25% larger than ☐ 50% larger than ☐ 75% larger than

☐ 25% smaller than ☐ 50% smaller than ☐ 75% smaller than

How was the visibility at the time of the collision?

☐ Poor ☐ Fair ☐ Good

What were the road conditions at the time of impact?

☐ Clean and Dry ☐ Wet ☐ Icy

Did you see the collision coming?

☐ Anticipated the collision ☐ Did not anticipate the collision

Were you braced for the impact?

☐ Was braced for the impact ☐ Was not braced for the impact

Were you wearing a seatbelt?

☐ Was wearing a seatbelt with shoulder harness ☐ Was not wearing a seatbelt

☐ Was wearing a seatbelt without a shoulder harness

Did you sustain any bruises from the seatbelt? ☐ No ☐ Yes, please list location

_____

How was the top of your head rest positioned?

☐ Even with the top of the head ☐ Even with the bottom of the head

☐ Even with the middle of the neck ☐ Even with the upper back

What was your head position at time of impact?

☐ Facing straight forward ☐ Turned to the left ☐ Turned to the right

☐ Flexed downward ☐ Extended upward

Patient Name:_____

What was your hand position during the accident?

☐ Both hands on the steering wheel ☐ The right hand on the steering wheel

☐ The left hand on the steering wheel

What was your body position at time of impact?

☐ Good ☐ Slumping forward ☐ Lying down sideways in the back seat

☐ Reclining in front seat ☐ Reaching onto the floorboard ☐ Turning around in my seat

☐ Leaning sideways

Was there any loss of consciousness? ☐ Yes ☐ No

Did the airbags deploy? ☐ Yes ☐ No

Did the seat break? ☐ Yes ☐ No

Were any objects thrown around inside of the car? ☐ Yes ☐ No

If yes, please list: _____

Did any part of your body strike the inside of the car? ☐ Yes ☐ No

If yes, please list:_____

Did you have the brakes applied at time of impact? ☐ Yes ☐ No

Did the police arrive at the scene? ☐ Yes ☐ No

Was a police report filled out?

☐ Yes, already filled out ☐ No, Was not filled out ☐ Will be filled out

Who Received a ticket?

☐ You ☐ The driver of the other vehicle ☐ You AND the driver of the other vehicle

Did EMT's/Paramedics arrive at the scene? ☐ Yes ☐ No

Were you taken to the hospital by ambulance? ☐ Yes ☐ No

What aid/support was used after accident? (Ex. Neck brace, crutches, medication, etc)

_____

What aid/support is currently being use? (Ex. Neck brace, crutches, medication, etc)

_____

How did your vehicle leave the scene?

☐ Towed ☐ Driven away

How did the other vehicle leave the scene?

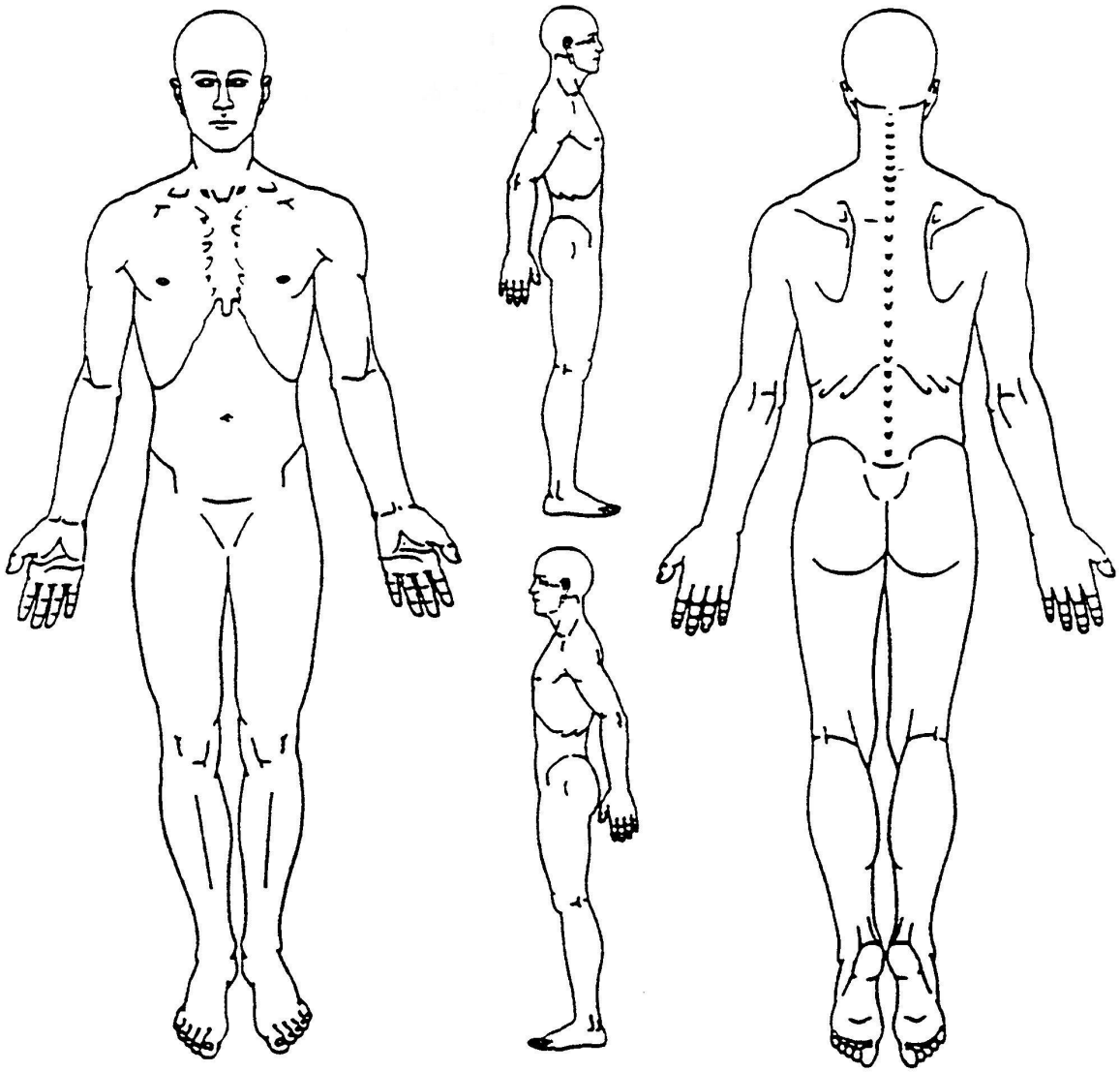
☐ Towed ☐ Driven away ☐ ☐

What was the estimated cost of the damage to the vehicle you were in? $_____

Please describe the accident details in your own words:

_____
_____
_____
_____
_____
_____

Please mark an "X" in all areas you are having pain.



Please indicate your level of pain from 0-10 for the following regions of your neck and back.

0 = No Pain, 10 = Worst possible pain

Neck:_____ Upper Back: _____ Mid Back:_____ Lower Back:_____