



Auto Injury Intake Form

Patient Name: _____

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

Date and Time of Accident: _____

Insurance/Claim: _____

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

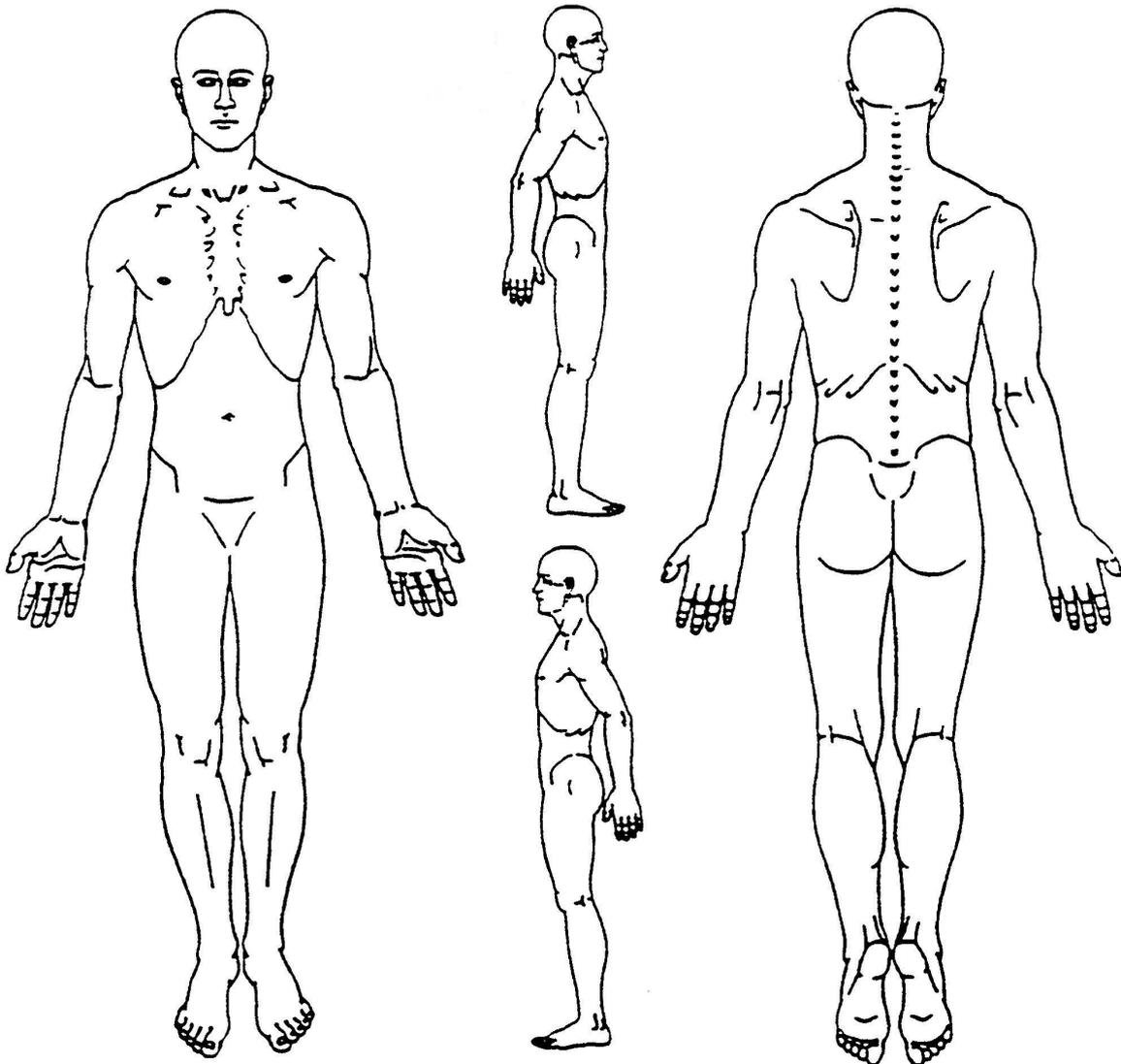
How did the other vehicle leave the scene?

- 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: _____