PDX CHIROPRACTOR

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Injury Intake Form

Today's Date: _______________

Patient Name: _______________________________________ **Date of Birth:** _______________________________

Date of Accident: ________________________ **Time of Accident:** ____

Location of Accident: ____

Driver's Name: _____________________________________ **Year:** _______ **Make:** ________ **Model:** __________

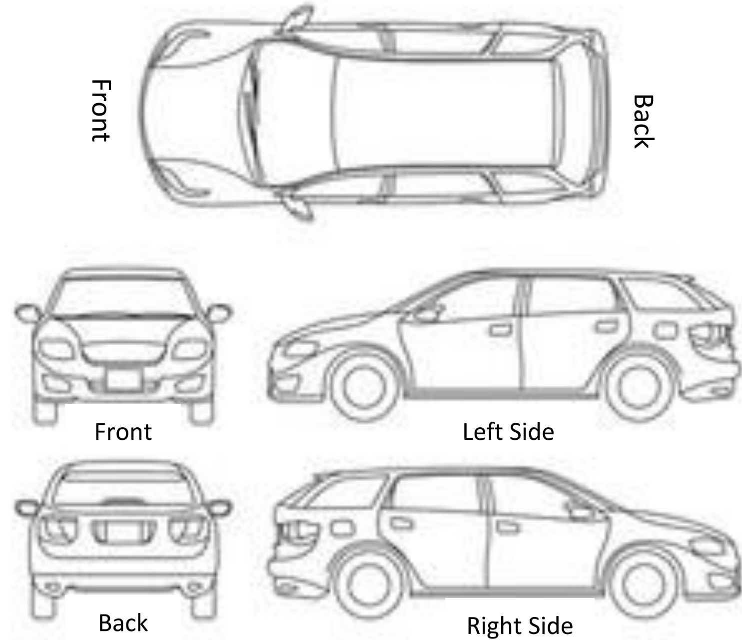
3rd Party Driver's Name: _____________________________ **Year:** _______ **Make:** ________ **Model:** __________

Description of Accident: ____

____

____

Mark the area that was damaged:



Accident Details:

Where were you seated (driver, front passenger, rear passenger)? __________________________________

Name of Driver: ______________________________

Was there anyone else in the car? ☐ Yes ☐ No

Name: ____

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What was the estimated speed of your vehicle at the time of the accident? ______________________________

The road conditions at the time of the accident were: (dry, wet, rain, snow, other)? ______________________

What was the estimated speed of the other vehicle: ____

What position was the headrest in: lowest, middle or top position, other? _______________________________

Did you use a: Shoulder/lap belt, lap belt only, no seatbelt used, other? _________________________________

Did your airbag deploy as a result of the accident? □ Yes □ No

If yes, were you struck by the airbag? □ Yes □ No

At the time of the impact, what was your head position: facing forward, looking up/ down, turned to the left/ right, other. Explain: ____

At the time of the impact, what was the position of your body: facing forward, leaning back/ forward, turned to the left/ right, other. Explain: ____

Were you aware of the impending collision with the other vehicle? □ Yes □ No

Did you brace for the impact? □ Yes □ No

Were your hands on the steering wheel at the time of impact? □ Yes □ No

If yes, which hand(s): both left only right only

Was your foot on the brake pedal at the time of impact? □ Yes □ No

Did the collision move your vehicle? □ Yes □ No

If yes, how far? ___________________

What happened to you at the time of impact? (Head hit headrest, etc.) ____

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

If yes, explain: ____

Did you lose consciousness after the accident? □ Yes □ No

If yes, for how long? ____

Describe the damage of your vehicle: ____

Did the police respond to the accident? □ Yes □ No

Was a report file? □ Yes □ No

Was the Ambulance/ EMS at the scene? □ Yes □ No

If yes, what hospital did you go to? ____

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Did you go to the doctor/ clinic before today? □ Yes □ No

If yes, what's the name of the clinic? ____

Were you examined? □ Yes □ No

Were any X-ray, MRI, or CT scan taken? □ Yes □ No

Was there any medication being prescribed? □ Yes □ No

Medication Name: ____

Immediately after the accident were you: dizzy, nauseous, vomiting, confused, disoriented, dazed, shock, other:

____

Could you move all parts of your body? □ Yes □ No

If no, explain: ____

Could you exit the car unaided? □ Yes □ No

Symptoms:

Location of your pain: □ Headache □ Neck □ Shoulders □ Upper Back □ Low Back □ Arms □ Legs □ Other:

____

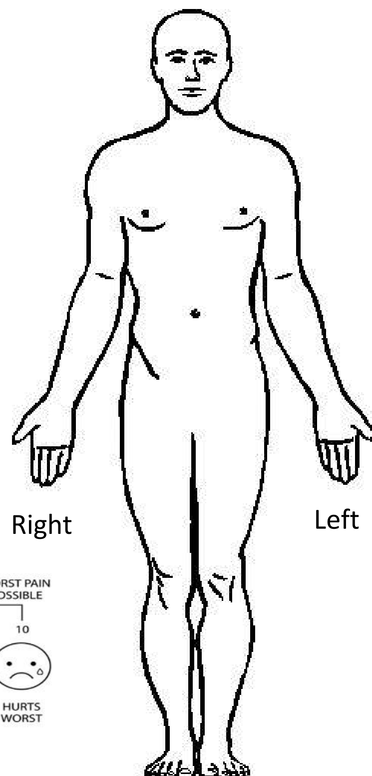
____

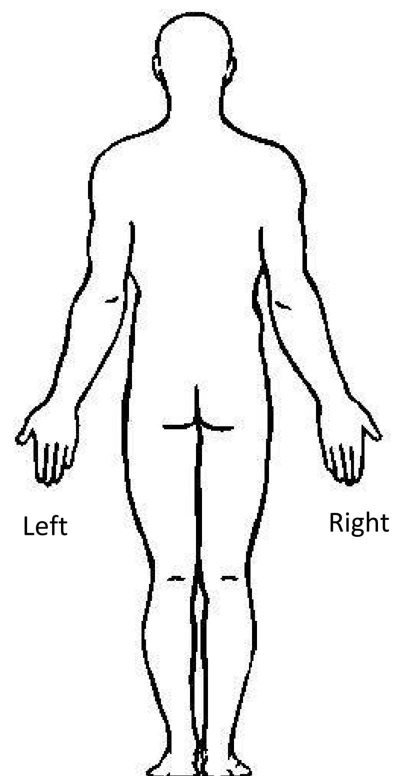
Describe your pain: □ Sharp □ Aching □ Dull □ Stabbing □ Burning □ Throbbing □ Pulsing □ Other:

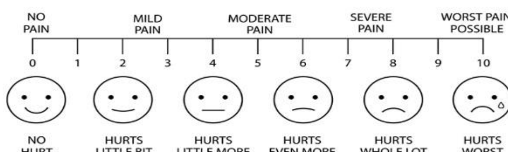
____

How often is your pain present: □ 76-100% of day □ 75-50% of the day □ 49-25% of day □ 24-0% of day

Mark the areas (circle/shade) where the symptoms are present:
On a scale of 0 to 10







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Do you have:

Upper Extremities (Hands)
□ Numbness
□ Tingling
□ Radiating pain
□ weakness
□ Cut/ Bruises

Lower Extremities (Legs)
□ Numbness
□ Tingling
□ Radiating pain
□ weakness
□ Cut/ Bruises

Do you have:

Dizziness: □ Yes □ No
Jaw Pain (TMJD): □ Yes □ No
Problem Focusing: □ Yes □ No
Visual changes: □ Yes □ No
Blurriness/ Double vision/ Floaters/ Dark spots
Light Sensitivity □ Yes □ No

Tinnitus (ear noises/ sounds): □ Yes □ No
Noise Sensitivity □ Yes □ No
Easily Fatigue □ Yes □ No
Headaches: □ Yes □ No
Loss of balances: □ Yes □ No
Bowel/ Bladder changes: □ Yes □ No

When did your pain occur: □ Immediately □ Few hours later □ That night □ Next Day □ Few days later

□ Other: ____

Have you been experiencing pain in any of these areas before this injury? □ Yes □ No

If yes, explain: ____
____
____

Since the accident are you felling: □ Better □ Worse □ Same

What position make the pain better if any: □ Laying Down □ Sitting Changing positions often
□ Standing □ Nothing make the pain better

What position makes the pain worse if any: □ Laying Down □ Sitting □ Standing □ Bending □ Lifting

□ Walking □ Reaching □ Kneeling □ Squatting □ Staying in prolonged positions

What have you tried at home to help: □ Massage □ Laying Down □ Hot bath/shower □ Ice □ Heat

□ Pain Medication □ Pain Cream □ Rest Other: ______________________________

Did it help? □ Yes □ No □ A little

Have you missed any work? □ Yes □ No

If yes, how many days have you missed? ______________________________

What is your work schedule like? Full Time Part Time

Patient/ Guardian Signature: ______________________________ Date: ______________

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Health History:

Medications: List the medications you are currently taking: ____

____

____

Allergies: ____

____

Do you have any serious illnesses or conditions? □ Yes □ No

If yes, explain: ____

____

Have you been hospitalized before? □ Yes □ No

If yes, explain: ____

____

Have you had any surgeries? □ Yes □ No

If yes, explain: ____

Have you experienced any previous physical trauma? □ Yes □ No

Have you had any other accidents? □ Yes □ No

Have you ever had any X-ray before? □ Yes □ No

Do you drink alcohol? □ Yes □ No

If yes, how much, how often? ____

Do you use tobacco? □ Yes □ No

If yes, how much, and for how long? ____

Family Heath History (only your grandparents, parents, aunts, uncle and/or siblings): (please circle and explain who had/ has the condition.)

Cancer _______________ Heart Disease _______________ High blood pressure _______________

Low blood pressure ________________ Epilepsy _______________ Asthma _______________

Stroke _______________ Diabetes _______________