Auto Accident Intake Form

Brian Cox PT & Chiro
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Name: _____ ☐ Male ☐Female Date:_____

Address: _____ City:_____ Zip:_____

Home/Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: ____ E-Mail (Confidential):_____

Primary Doctor: _____ Private Insurance Plan: _____

Who introduced you to us? _____

Date of Accident:_____

Have you reported it to your car insurance company? ☐No ☐Yes

Auto Insurance Name:_____ Claim #:_____

Insurance Adjustor's Name:_____ Adjustor's Phone #:_____

Have you hired an attorney? ☐No ☐Yes Name:_____

Accident Data at the Moment of Impact:

Your vehicle type: ☐Compact Car ☐Mid-size Car ☐Full-size Car ☐Pick-up Truck ☐Minivan ☐Other:_____

Your position in the vehicle: ☐Driver ☐Passenger ☐Front ☐Back ☐Left ☐Right

Speed of vehicle: ☐Stopped ☐Moving approximately ____ MPH ☐Unsure of Speed

Collision Type: ☐Driver side ☐Passenger Side ☐Front ☐Head-on ☐Rear ☐Pedestrian

The Other vehicle Type: ☐Compact Car ☐Mid-size Car ☐Full-size Car ☐Pick-up Truck ☐Minivan ☐Other:_____

Speed of the Other Vehicle: ☐Stopped ☐Moving approximately ____ MPH ☐Unsure of Speed

At the moment of impact you were: ☐Totally unaware the accident was impending ☐Aware it was coming ☐ Aware and braced for it

At impact were you: ☐Using a seatbelt ☐Not using a seatbelt

At impact: ☐The vehicle had no airbag ☐Airbag deployed ☐Airbag not deployed

The position of your head was: ☐Facing straight ahead ☐Rotated to left ☐Rotated to right

The position of your body was: ☐Facing straight ahead ☐Rotated to left ☐Rotated to right

At impact: ☐Your head struck dashboard ☐Your head struck windshield ☐Your head struck side window ☐Other: _____

Damage to the vehicle you were in: ☐Minimal ☐Moderate ☐Severe ☐Totalled ☐Unknown

Was a police report filed? ☐No ☐Yes

Did you lose consciousness? ☐No ☐Yes

How did you feel? ☐Dizzy ☐Disoriented ☐Nauseated

Were you able to walk unaided? ☐No ☐Yes

Where did you go? ☐Home ☐Work ☐Hospital ☐Other:_____

In what area(s) did you immediately feel pain?

☐	Head	☐	Shoulder	L	R	☐	Hip	L R
☐	Neck	☐	Arm	L	R	☐	Thigh	L R
☐	Upper Back	☐	Elbow	L	R	☐	Knee	L R
☐	Mid Back	☐	Wrist	L	R	☐	Calf	L R
☐	Ribs	☐	Hand	L	R	☐	Ankle	L R
☐	Chest	☐	Fingers	L	R	☐	Foot	L R
☐	Abdomen	☐	Buttock	L	R	☐	Toes	L R
☐	Low Back							
☐	Pelvis							

Did any new area(s) experience pain in the time following the accident? ☐No ☐Yes

In what area(s) did you feel pain following the accident? Circle **L** = Left **R** = Right

☐	Head	☐	Shoulder	L	R	☐	Hip	L R
☐	Neck	☐	Arm	L	R	☐	Thigh	L R
☐	Upper Back	☐	Elbow	L	R	☐	Knee	L R
☐	Mid Back	☐	Wrist	L	R	☐	Calf	L R
☐	Ribs	☐	Hand	L	R	☐	Ankle	L R
☐	Chest	☐	Fingers	L	R	☐	Foot	L R
☐	Abdomen	☐	Buttock	L	R	☐	Toes	L R
☐	Low Back							
☐	Pelvis							

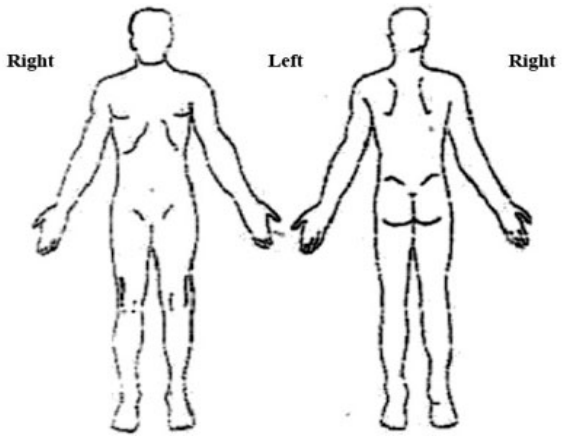
How long after the accident these symptoms first appear? ☐Hours ☐Next Day ☐2 Days Later

☐Other_____

List the Problem(s) Caused by the Accident and Circle the Number that Best Represents Your Pain: PreMVA

1. _____ 0 . 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10 _____
   (no pain) (pain) (worst)
2. _____ 0 . 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10 _____
   (no pain) (pain) (worst)
3. _____ 0 . 1 . 2 . 3 . 4 . 5 . 6 . 7 . 8 . 9 . 10 _____
   (no pain) (pain) (worst)

Mark below the areas you feel: **P** = Pain, **N**= Numbness



Check the box of your problem's location:

☐ Head				☐ Arm	L	R	B
☐ Neck				☐ Pelvis/Hip	L	R	B
☐ Upper Back				☐ Thigh	L	R	B
☐ Mid Back				☐ Knee	L	R	B
☐ Low Back				☐ Lower Leg	L	R	B
☐ Shoulder	L	R	B	☐ Ankle	L	R	B
☐ Chest	L	R	B	☐ Foot	L	R	B

Circle **L** = Left **R** = Right **B** = Both

How much of the day do you have symptoms? ☐100% ☐75% ☐50% ☐25% ☐0%

Did you have these problems before the accident? ☐No ☐Yes When?_____

What activities has this problem affected? ☐Sitting ☐Standing ☐Walking ☐Lying Down ☐Sleeping ☐Driving ☐Work Duties ☐Exercising ☐Other:_____

What percent of your work activities are you able to perform?

0% . 10 . 20 . 30 . 40 . 50 . 60 . 70 . 80 . 90 . 100%

What percent of your home activities are you able to perform?

0% . 10 . 20 . 30 . 40 . 50 . 60 . 70 . 80 . 90 . 100%

What percent of your recreational activities are you able to perform?

0% . 10 . 20 . 30 . 40 . 50 . 60 . 70 . 80 . 90 . 100%

(over)

What relieves this problem? ☐Sitting ☐Standing ☐Walking ☐Lying Down ☐Other:_____

Have you had any tests for this? ☐No ☐X-Ray ☐MRI ☐Cat Scan ☐Other:_____

Which facility?_____ When?_____ Do you have them? ☐No ☐Yes

Have you seen other providers for this condition? ☐No ☐Yes If so, please list their:

Name:_____ Diagnosis: _____ Treatment:_____

Name:_____ Diagnosis: _____ Treatment:_____

Please Complete Your Health History:

Circle **L** = Left **R** = Right **B** = Both

Chronic pain or problem: ☐Neck ☐Mid Back ☐Low Back

☐ Shoulder: L R B ☐Hip: L R B ☐Knee: L R B ☐Ankle: L R B ☐Foot: L R B

Ever diagnosed with the following conditions? ☐Whiplash ☐Disc Bulge or Herniation ☐Disc Degeneration ☐Arthritis of Neck or Back ☐Stenosis ☐Osteopenia ☐Osteoporosis

List any other Spine, Joint, or Health Conditions: _____

List any Surgery (date): _____

Cancer? ☐No ☐Yes Type:_____ Heart Condition? ☐No ☐Yes Type:_____

Occupation:_____ Hobbies/Interests:_____

Do you exercise regularly? ☐No ☐Yes What is it? _____

Do you feel you are having anxiety or stress that is affecting your health? ☐No ☐Yes

Your Expectations:

Do you have any questions about treatment? ☐No ☐Yes What? _____

What are your specific health goals, besides having less pain? _____

What things that mean the most to you have you been missing out on? _____

Authorization and Release: _____

I authorize my insurance benefits to be paid to Balanced Body PT & Chiro.

I consent to release related diagnostic reports to Balanced Body PT & Chiro.

I have been provided an opportunity to review the Notice of Privacy Practices.

I acknowledge that I am financially responsible for all fees not covered by insurance.

I authorize Brian Cox, DC, PT, for treatment of my child _____.

_____

Patient Signature