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Motor Vehicle Accident Intake Form

Name_____ Date of Birth _____

Date of Accident _____ Time of Accident _____AM/PM

Year/Make/Model of Your Car _____ Approx. Damage to your Car _____

Year/Make/Model of Other Car _____ Approx. Damage to Other Car _____

Visibility at Time of Accident Poor Fair Good **Road Conditions** Dry Wet Icy
Type of Accident (circle): Head On / Rear End / Broad Side / Pedestrian / Rear Ended Car in Front
_____Non-Collision (describe) _____

Describe and Draw What Happened

_____

_____

Estimated Speed of Your Vehicle _____MPH Speed of Other Vehicle_____ MPH

Did You Brace For Impact? _____ Were the Brakes On? _____ Did Airbag Deploy? _____

I Was Wearing a: Lap belt? _____ Shoulder Harness_____ or Both _____

Top of Headrest Reached _____ (neck, top of head, etc.)

Any loss of Consciousness _____? For how long? _____

Describe How You Felt Immediately After _____

Were You Taken to the Hospital (if yes, which one) _____

Any x-rays Taken? YES NO

Describe How You Felt That Night _____

Describe How You Felt the Next Day _____

Have You Missed Work as a Result? _____ Dates Missed _____

Are You Taking Anything for Pain _____

Have You Ever Experienced Similar Symptoms to What You are Experiencing Now?

Please Describe _____

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Have You Seen Other Doctors For This Injury?

Doctor #1 _____ X-Rays Taken? _____

Doctor #2 _____ X-Ray Taken? _____

Dates of Previous Auto Accidents _____

Chief Complaint #1

PROVOKING (what activities aggravate your injury) -Circle-
Sitting / Standing / Lying / Walking / Reaching / Bending / Other

PALLIATIVE (what makes it feel better) -Circle-
Ice / Heat / Lying / Pain Med. / Stretching / Other

QUALITY (describe the pain) -Circle-
Sharp / Electric / Burning / Stabbing / Aching / Deep / Other

Any sensations **radiating** into the following? -Circle-
Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades

Describe the radiating -Circle-
Sharp / Dull / Tingling / Numbness / Prickling / Other

Please rate your pain:
On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) -Circle-
Early Morning / Mid-Day / Late Eve / After Work / After Exercise / Other

Chief Complaint #2

PROVOKING (what activities aggravate your injury) -Circle-
Sitting / Standing / Lying / Walking / Reaching / Bending / Other

PALLIATIVE (what makes it feel better) -Circle-
Ice / Heat / Lying / Pain Med. / Stretching / Other

QUALITY (describe the pain) -Circle-
Sharp / Electric / Burning / Stabbing / Aching / Deep / Other

Any sensations **radiating** into the following? -Circle-
Arms / Legs / Forearm / Hands / Buttock / Thighs / Foot / Shoulder / Shoulder Blades

Describe the radiating -Circle-
Sharp / Dull / Tingling / Numbness / Prickling / Other

Please rate your pain:
On a scale of 0 - 10 with 0 being no pain and 10 pain that prevents ALL activities _____

PATTERN (time of day most aggravated) -Circle-
Early Morning / Mid-Day / Late Eve / After Work / After Exercise / Other

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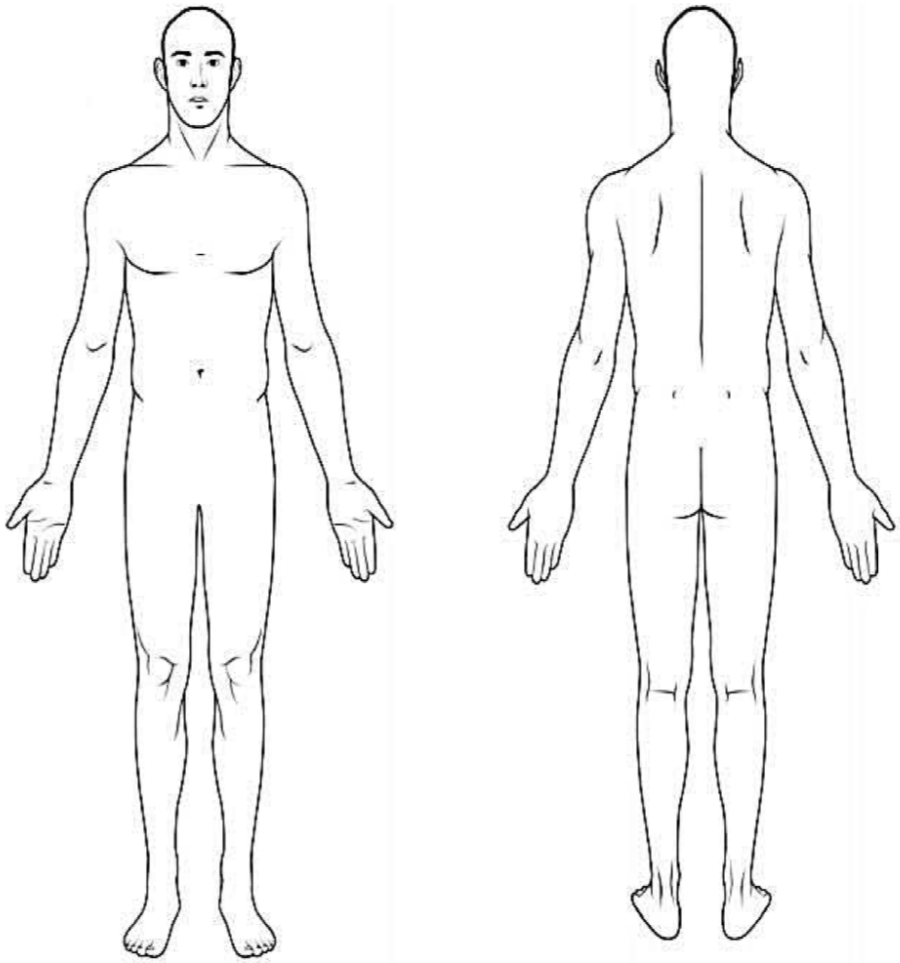
Please mark where you pain is located. Use the following key:

B = Burning
S = Stabbing
A = Aching
N = Numbness
P = Pins and Needles
O = Other



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