STEELE CHIROPRACTIC

Auto Accident Intake Form

Today's Date_____ Primary Phone:_____

Name:_____ Secondary Phone:_____

Address: _____ Social Security #:_____

_____ Date of Birth:_____

Sex **MALE** **FEMALE** Marital Status:_____

Occupation:_____ Have you ever been to a chiropractor before?

Employer:_____ YES NO

Employer Phone #: _____

Accident Information

Date of accident:_____ Time of accident:_____

Were the police notified? YES NO

Were you wearing a seatbelt? YES NO

Were you the ___driver ___passenger ___pedestrian

If passenger, were you sitting in ___front ___right backset ___left backseat

Did **your** vehicle strike the other? YES NO

Did the **other** vehicle strike yours? YES NO

Please describe in detail how the accident happened?_____

_____

_____

_____

Auto Accident Insurance Information

Your Insurance Company:_____ Phone #_____

Address:_____City/State/Zip_____

Claim #:_____ Do you have an attorney? YES NO

Name of other vehicles driver:_____

Other vehicles insurance company:_____

Other vehicle insurance company phone #:_____ claim #:_____

Post-Accident Information

Where did you feel pain **immediately** after the accident?_____

Rate your pain **today** on a scale of 1-10 (1 being no pain and 10 being unbearable)_____

Please describe your **pain(s)**(burning, sharp, tight etc) and **location(s)** :_____

_____

_____

Have you experienced pain in this location(s) before? **NO** **YES** (when)_____

When did these symptoms begin? **IMMEDIATLEY** **LATER, SAME DAY** **DIFFERENT DAY**

Since the accident has your condition: **IMPROVED** **WORSENED** **STAYED SAME**

Does anything make your condition improve? **NO** **YES** _____

Does anything make your condition worse? **NO** **YES**_____

Have you seen any other doctor(s) since the accident: **NO** **YES** (name)_____

Did you require hospitalization: **NO** **YES** (name)_____

Did you have an X-ray, MRI or any other tests for this condition? **NO** **YES** (describe)_____

Check off current symptoms: ___headaches ___neck pain/stiffness __mid back pain ___low back pain ___nausea
___cold hands/feet ___leg pain ___pain behind eyes ___loss of smell ___loss of taste ___chest pain ___dizziness
___shortness of breath ___ringing in ears ___fatigue ___anxiety ___sleeping problems ___tension ___tension
___fainting ___irritability ___depression ___confusion ___constipation ___nervousness ___other:_____

Health History:

Please list all medications you are currently taking for this or any health condition (including vitamins):

_____

_____

Please list any allergies (including medications, environmental, food): _____

_____

Please list **any** medical conditions that you **currently have or have had** (cancer, diabetes, high blood pressure, dizziness etc):_____

_____

_____

Please list **any** surgeries you have had from **birth-present**:_____

_____

_____

Do you smoke? **NO** **YES** (how much)_____ (for how long)_____

Former Smoker, but quit Years since last smoked_____

For Women: Are you currently taking birth control? **NO** **YES** (name)_____

Are you pregnant? **NO** **YES** due date_____/_____/_____

Patient Signature:_____ Date:_____