AUTOMOBILE ACCIDENT INTAKE FORM

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1. First Name: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Male ○ Female

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt#: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

E-Mail: _____

Preferred contact method:
○ Mobile Phone ○ Text ○ Email
○ Home Phone ○ Work Phone

SSN: _____ DL#: _____

Height: _____ Weight: _____

Occupation: _____ Employed by: _____

Name of your physician: _____ Physician's location (CITY): _____

Date of accident: _____ Time of accident: _____ AM or PM?
○ AM ○ PM

City of accident: _____ Street of accident: _____

Road conditions at the time of accident:
○ Wet ○ Dry ○ Icy ○ Other

If other, please describe: _____

2. Did the police come to the accident scene?
○ Yes ○ No

Is there a report?
○ Yes ○ No

Did you go to the hospital?
○ Yes ○ No

- If yes, what is the name and city of the hospital: _____

- How did you get to the hospital? _____

- What parts of your body were x-rayed at the hospital?

- What did the hospital do for your injuries?

- How long did you stay at the hospital?

What bleeding cuts did you sustain during this accident?

What bruises did you sustain during this accident?

In which seat were you seated in the vehicle?
○ Driver ○ Front passenger ○ Back passenger, driver side ○ Back passenger, middle seat
○ Back passenger, right side ○ Other

If other, please describe in which seat you were seated:

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?
○ Aware ○ Surprise

Did you lose consciousness (black out) upon impact?
○ Yes ○ No

For how long?

Did you experience a flash of light or explosion in your head?
○ Yes ○ No

Is the top of the headrest/seatback above or below the top of your head?
○ Above ○ Below

By how many inches? (approximately)

Were you wearing a seatbelt?
○ Yes ○ No

What kind of seatbelt?
○ Traditional shoulder-lap seatbelt ○ Lap seatbelt

3. Did you receive any injury or bruise from the seatbelt?
○ Yes ○ No

- If yes, then describe:

Was your torso pointed straight forward at the time of the collision?
○ Yes ○ No

- If no, what direction was it pointed and by how much?

Was your head pointed straight forward?
○ Yes ○ No

- If no, what direction was it pointed and by how much?

What is the estimated cost damage to the vehicle you were in?

Which of the following car parts broke during the accident?
☐ Windshield ☐ Front seat ☐ Back right/left side window ☐ Steering wheel
☐ Other

Other:

4. On what part of the automobile did your following body parts hit?

HEAD HIT:

CHEST HIT:

RIGHT/LEFT SHOULDER HIT:

RIGHT/LEFT ARM HIT:

RIGHT/LEFT HIP HIT:

RIGHT/LEFT LEG HIT:

RIGHT/LEFT KNEE HIT:

OTHER:

5. List the year, make, and model of the vehicle you were in:

Year:

Make:

Model:

6. Was your car stopped at the time of impact?
○ Yes ○ No

- If yes, was the driver's foot also on the brake?
○ Yes ○ No

- If no, then estimate the speed of the vehicle you were in:

7. If your vehicle was moving at the time of impact, was it:

	YES	NO
Slowing down?		
Gaining speed?		
Traveling at a steady rate of speed?		

8. What is the year, make and model of the other vehicle?

Year:

Make:

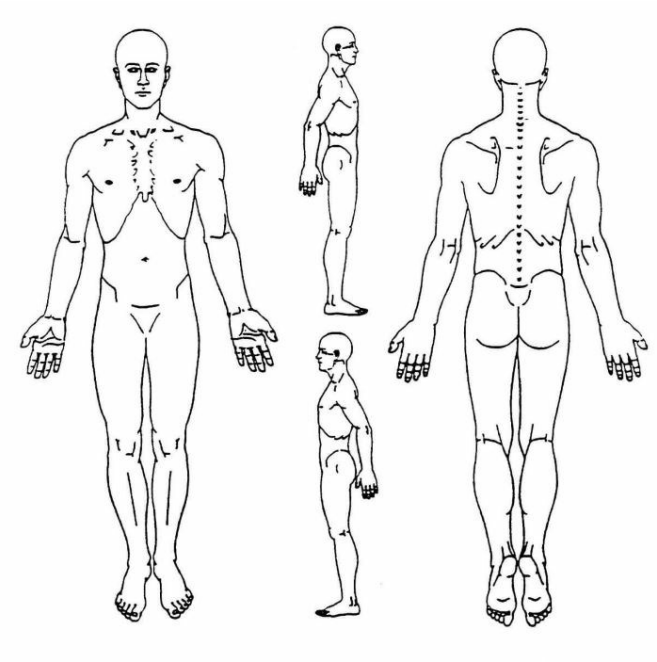
Model:

9. Was the other vehicle moving at the time of collision?
○ Yes ○ No

If yes, what was its approximate speed?

If the other vehicle was moving at the time of collision, was it:
○ Slowing down ○ Gaining speed ○ Traveling at a steady speed

10. If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking, numbness, burning, etc.



The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.

0 means no disability at all and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing)

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

11. Please type a number in each blank provided below.

	ANSWER
1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.)	
2. RECREATION: hobbies, sports, and other similar leisure time activities.	
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions.	
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker.	
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.	
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing.	

12. Do you have an attorney representing you for the automobile accident you sustained?

○ Yes ○ No

If you answered yes, what is your attorney's name and phone number?

_____

If you are using any of the following insurance options, please select all that apply:

☐ Liability insurance from the at-fault party
☐ Personal Injury Protection under you own auto insurance policy
☐ Personal Injury Protection under someone else's auto insurance policy ☐ Uninsured Motorist Coverage
☐ None

If you selected any of the above, please tell us the name of the insurance company:

_____

What is the claim number?

_____

What is the phone number to reach your adjuster?

_____

Patient's Signature

_____ _____

Signature Date