Auto Injury Management
@ Complete Care Health Services
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AUTO COLLISION / PERSONAL INJURY INTAKE FORM

*(**Fill-in, Circle**, or Mark a ✔on each that applies, **N/A** if does not applicable, **Blank** if don't know)*

Today's Date: _____

Your Full Name: _____

Gender: ☐M ☐F **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Birth Date: _____/_____/_____ Age: _____

Height _____ **Weight** _____ **Handed:** RT: ___ LT: ____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Social Security No.: _____-_____-_____ **Driver's License No.**:_____

Home Phone: (____) _____ **Cellular Phone**: (_____)_____

E-Mail: _____ **Work Phone:** (_____) _____

Occupation: _____

Employer: _____

Employer Address: _____

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YOUR AUTO'S INSURANCE INFORMATION:

Insured's Name (name the policy in under): _____/_____
(Last) (First)

Relationship to patient (if policy is not under your name): _____

Insurance Company Name:_____

Auto Agents' Name: _____

Agent's phone Number: _____

Do you have Med-Pay coverage? ☐Yes ☐No **Amount of Coverage**? : _____

Do you have under-insured / un-insured coverage? ☐Yes ☐No

Have you been issued a Claim# for this accident? ☐Yes ☐No

Claim#: _____

Were you at fault for this accident? ☐ Yes ☐ No

Other Party's AUTO INSURANCE INFORMATION (IF APPLICABLE)

Other party's Name: _____

Insurance Company name of other person: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Claim Number: _____

Have you retained an attorney? ☐ Yes ☐ No

Your Attorney's Name: _____

Your Attorney's Phone#: (____) _____ Fax (____) _____

Your Attorney's Address: _____

City: _____ State: _____ Zip: _____

COLLISION INFORMATION:

Date of Collision: _____/_____/_____ **Time of Collision**: _____ a.m. / p.m.

The Weather Conditions were they: ☐ Sunny ☐ Raining ☐ Snowing ☐ Foggy

The Road was: ☐ Dry ☐ Wet ☐ Icy

Light of Day: ☐ Dawn ☐ Day ☐ Dusk ☐ Night

Your Vehicle: Year _____ Make _____ Model_____

Collision Type: ☐ Rear ended ☐ Head-on ☐ Broad-sided ☐ Side swiped

Damage to Your Vehicle: $ _____

☐ Drivable OR ☐ Towed away

Have you had your car repaired yet? ☐ Yes ☐ No

(if applicable)

Other Vehicle: Year _____ Make _____ Model_____

Other Vehicle Damage: ☐ Mild ☐ Moderate ☐ Severe

☐ Drivable OR ☐ Towed away

Unusual circumstances: (please note)

(i.e.: was anyone drunk, under the influence, emotionally unstable, speeding, out of control etc.)

_____

_____

Did you take Pictures? : ☐ Yes ☐ No

(If so, of what) ☐ My car ☐ Other car(s) ☐ Accident scene ☐ Injured body part(s)

COLLISION SPECIFICS:

Were you the: ☐ Driver ☐ Passenger

If passenger, where **were you** sitting: ☐ Front Seat OR ☐ Back Seat

☐ Right Side OR ☐ Left Side

Were you wearing your seatbelt: ☐ Yes ☐ No

Did the airbag deploy: ☐ Yes ☐No

Impending Collision, were you: ☐ Aware OR ☐ Unaware

☐ Braced OR ☐ Not brace

Right hand: ☐ Steering wheel ☐ Center console ☐ In Lap ☐ Door ledge ☐ Other: _____

Left hand: ☐ Steering wheel ☐ Center console ☐ In Lap ☐ Door ledge ☐ Other: _____

Right foot: ☐ Gas ☐ Brake ☐ Floor board ☐ Fire wall ☐ Other : _____

Left Foot: ☐ Gas ☐ Brake ☐ Floor board ☐ Fire wall ☐ Other : _____

Head position: ☐ Straight ahead ☐ turned left ☐ turned right ☐ bent down ☐ bent back

Torso position: ☐ Straight ahead ☐ turned left ☐ turned right ☐ bent down ☐ bent back

Head rest position: ☐ lowest positon ☐ middle position ☐ highest position

Seatback position: ☐ straight up-right ☐ slight recline ☐ full recline

Did any part of your body strike anything inside of your car: ☐ Yes ☐ No

If Yes what body part / what area of the car? _____ / _____

Were any inside parts of your vehicle displaced or broken: YES ☐ NO ☐
If yes list:

_____

_____

Were any personal items displaced or broken: YES ☐ NO ☐
If yes list:

_____

_____

Did you experience: ☐Shock ☐Loss of Consciousness ☐Whiplash ☐ Other _____

****

Describe Collision: _____

_____

_____

_____

_____

_____

_____

Draw a picture / Diagram of collision:

IMMEDIATE LAW ENFORCEMENT FOLLOWING THE COLLISION: *(Mark a ✓on each that applies)*

☐ Police were called
☐ Police showed to the scene
☐ No police, we just exchanged information
☐ Hit & Run, no information to exchange
☐ I was ticketed for the accident
☐ Other party was ticketed
☐ A Police report was done at the scene
☐ I filed a police report on my own
☐ I have copy of the police report

Police Department: _____ Officer's name: _____

****

Witnesses:

Was anyone else in the car with you: ☐ Yes ☐ No (If yes Who?):_____

Did any other person witness the accident? ☐ Yes ☐ No: (if Yes who?):

_____

IMMEDIATE MEDICAL HELP FOLLOWING THE COLLISION: *(Mark a ✓on each that applies)*

☐ Ambulance / Paramedics were called

☐ I was treated at the scene

☐ I was transported to Hospital by Ambulance

☐ Even though offered transport I opted not to: Why?_____

_____

☐ I went to the Hospital in my own / via friend / via family. When?_____

☐ X-rays / MRI were done at Hospital: What body area: _____

_____

☐ Medication was prescribed by the Hospital: What; _____

_____

☐ Follow-up care was recommended: What: _____

Name of Ambulance: _____

Name of Hospital; _____

****

OTHER DOCTORS SEEN FOR THIS COLLISION BEFORE COMING TO THIS OFFICE:

☐ Orthopedist ☐ Neurologist ☐ Psychiatrist ☐Physiatrist ☐ Chiropractor
☐ Acupuncturist ☐ General Practitioner ☐ Physical Therapist ☐ Massage Therapist
☐ Other: _____

If so give:

Clinic name Practitioner's Name Phone number Approximate Date(s) seen __

_____

_____

_____

_____

_____

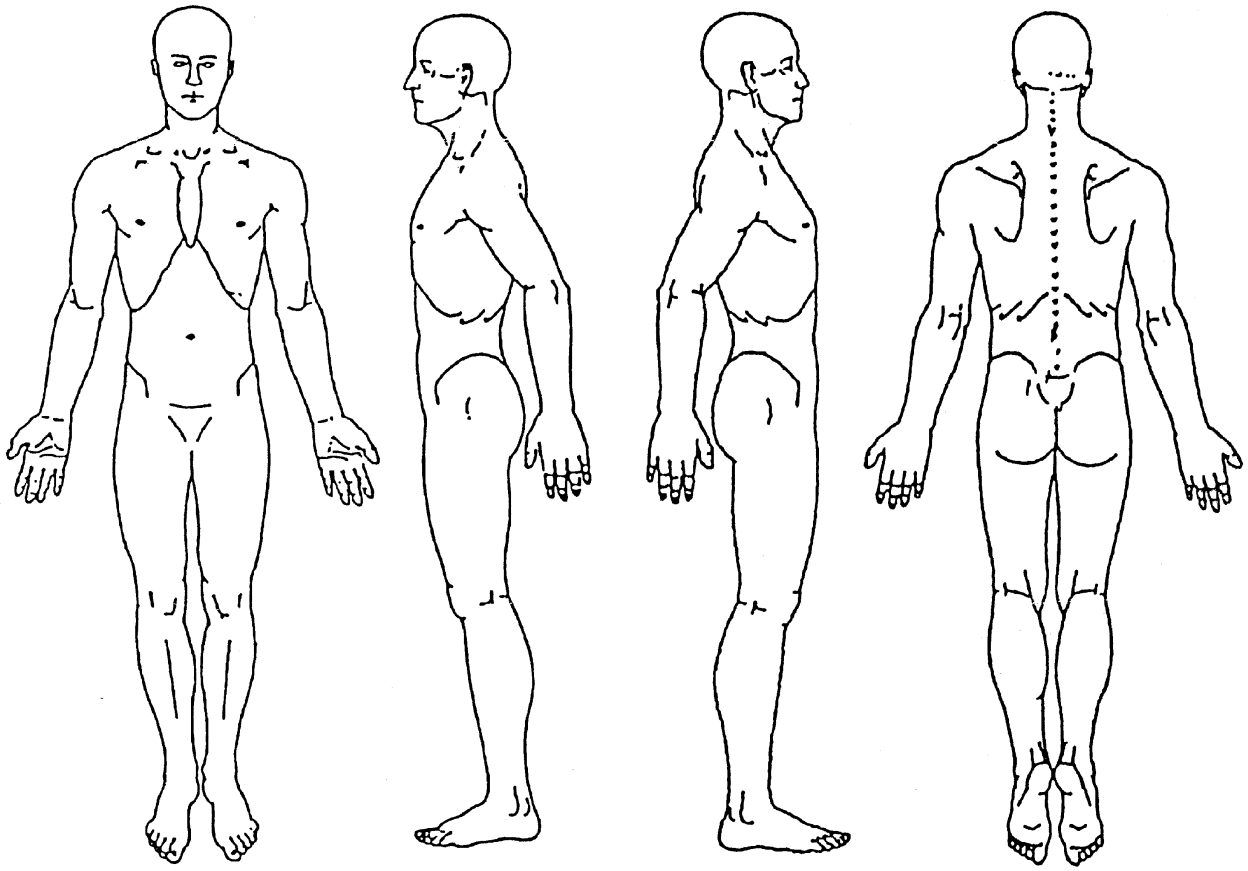
_____

_____

SYMPTOMATOLOGY: (Pain characteristics for MAJOR area(s) of complaint) FROM THIS COLLISION

Please use the legend symbols below to accurately mark the areas in which you feel these sensations:

Stabbing: SSSS Tingling-TTTT Burning-BBBB Cramping-CCCC
Numbness-NNNN Dull- DDDD Achy: AAAA Pin/ Needles: PPPP



(Muscle – Skeletal) :

Mark a ✓ on symptoms that have resulted DUE TO THIS COLLISION
Mark a X on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION

☐ Headaches/ Migraines	☐ Wrist/ Carpal Tunnel	☐ Leg/ Calf Pains
☐ Neck Pain	☐ Inside the Shoulder Pain	☐ Chest Pain
☐ Top of Shoulder Pain	☐ Elbow/ Arm Pain	☐ Abdomen Pain
☐ Mid-Back Pain	☐ Hand / Fingers Pain	☐ Problem Sleeping
☐ Along Shoulder Blades	☐ Hip Pain	☐ Numbness in Arms/ Hands
☐ Low Back Pain	☐ Knee Pain	☐ Numbness in Legs/ Feet
☐ Sacrum Pain	☐ Foot/ Ankle/ Toes	☐ Jaw Pain / clicking

(Cognitive / Emotional/ Sensory) :

Mark a ✓ on symptoms that have resulted DUE TO THIS COLLISION
Mark a X on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION

☐ Ringing in Ear ☐ Vertigo/ Dizziness ☐ Loss of Balance ☐ Fatigued
☐ Black outs ☐ Difficulty Concentrating ☐ Loss of memory ☐ Vison changes
☐ Reading Problem ☐ Sensitivity to Light ☐ Sensitivity to Sound ☐ Anxiety
☐ Highly Emotional ☐ Irritability ☐ Apathy ☐ Depression
☐ Social withdrawn ☐ Loss of Taste ☐ Loss of Smell ☐ Loss of Hearing
☐ Difficulty in Speech ☐ Night mares ☐ Sensitivity Hot / Cold
☐ Loss of Libido ☐ Thoughts of Suicide ☐ Typing / Writing Problems

(Systematic):

Mark a ✓ on symptoms that have resulted DUE TO THIS COLLISION
Mark a X on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION

☐ Asthma ☐ Digestive Problems ☐ Allergies ☐ Shortness of Breath ☐ Extreme Thirst
☐ Weight Loss /Gain ☐ Nausea / Vomiting ☐ Menstrual Irregularities ☐ High Blood Pressure

(Miscellaneous):

☐ Other _____
☐ Other _____

****

Self-Care:

What do you do for yourself to relieve any the symptoms? (*(Mark a ✓on each that applies)*

☐ Take Non-Prescription / over the counter Medications
☐ Take prescription Medications
☐ Recreational drugs
☐ Use ice
☐ Use heat
☐ Get extra Rest / sleep
☐ Do Stretches
☐ Do Exercises
☐ Massage self
☐ Massage from family member / friend
☐ Other:_____

Effects of your injuries / symptoms:

Please mark a ✓on each that applies to your activities affected by injuries due to this collision:

☐ Have to hold onto something to sit or stand from a chair.
☐ Stay at home most of the time.
☐ Have to sit most of the day.
☐ Stays in bed most of the day.
☐ Change position frequently to try and get comfortable.
☐ Have difficulty turning over in bed.
☐ Have to lie down and rest frequently.
☐ Have to get other people to do things for me.

Please mark a ✓on each that applies to Difficulties you are having in your daily activities affected by injuries due to this collision:

☐ Driving the car	☐ Bathing self	☐ Going to Restroom
☐ Climbing Stairs	☐ Walking	☐ Dressing Self
☐ Brushing teeth	☐ Combing Hair	☐ Shaving
☐ Doing Laundry	☐ Ironing	☐ Cooking
☐ Vacuuming	☐ Washing Dishes	☐ Dusting
☐ Movie going	☐ Dining Out	☐ Shopping
☐ Kneeling	☐ Social events	☐ Going to Church.
☐ Sexual relationships	☐ Reading	☐ Watching TV
☐ Child care	☐ Using phone	☐ Computer work
☐ Mowing Lawn	☐ Gardening	☐ Washing Car
☐ House Maintenance	☐ Landscaping	☐ Taking out Trash
☐ Aerobic exercising	☐ Backpacking	☐ Basketball
☐ Bowling	☐ Boxing	☐ Bicycling
☐ Basketry	☐ Baseball	☐ Fishing
☐ Fencing	☐ Dancing	☐ Camping
☐ Card Playing	☐ Handball	☐ Golf
☐ Football	☐ Judo	☐ Hunting
☐ Hockey	☐ Health Club	☐ Gymnastics
☐ Yoga	☐ Petitioning	☐ Karata
☐ Ice Skating	☐ Horseback riding	☐ Sailing
☐ Rafting	☐ Racquetball	☐ Photography
☐ Jogging	☐ Swimming	☐ Snow Skiing
☐ Sewing	☐ Weightlifting	☐ Water sports

Other: _____

How do the following positions or motions affect your pain?

	No Change	Relieves	Increased	If increases Duration limited to?
Sitting	☐	☐	☐	_____ hours / minutes
Walking	☐	☐	☐	_____ hours / minutes
Standing	☐	☐	☐	_____ hours / minutes
Lying Down	☐	☐	☐	_____ hours / minutes
Looking up	☐	☐	☐	_____ hours / minutes
Looking Down	☐	☐	☐	_____ hours / minutes
Lifting	☐	☐	☐	_____ weight / repetitions
Bending	☐	☐	☐	_____ _____ / _____

EMPLOYMENT HISTORY / CHANGE

WERE YOU EMPLOYED AT THE TIME OF THE COLLISION?: YES ☐ NO ☐
DID YOU LOOSE YOUR JOB DUE TO THIS COLLISION?: YES ☐ NO ☐

Employer: _____
Company name: _____
Supervisor / Boss name; _____

Your job Title: _____
Your job Duties:
_____
_____

Loss time from work due to this collision?: YES ☐ NO ☐

If yes:
Day: Date: Amount of time:
_____
_____
_____
_____

Has /Have you and or your Boss modified any your work responsibilities due to the effects of this collision? YES ☐ NO ☐
IF SO EXPLAIN:
_____
_____
_____
_____

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OTHER DOCTORS SEEN NOT FOR / BEFORE THIS COLLISION:

☐ Orthopedist ☐ Neurologist ☐ Psychiatrist ☐ Physiatrist ☐ Chiropractor
☐ Acupuncturist ☐ General Practitioner ☐ Physical Therapist ☐ Massage Therapist
☐ Other: _____

If so give:
Clinic name Practitioner's Name Phone number Date(s) seen
_____
_____
_____
_____
_____
_____
_____

PRIOR MEDICAL HISTORY:

LIST MEDICAL CONDITIONS YOU HAVE BEEN TREATED FOR **OUTSIDE OF AND /OR BEFORE** CONDITIONS DUE TO THIS CAR COLLISION:

_____

_____

_____

_____

_____

_____

List Past Surgeries: ☐ None

_____

_____

_____

_____

List current medications: ☐ None

_____

_____

_____

_____

I verify I have reviewed pages 1 through10 of this Auto Collision / Personal Injury Intake form and the information I have provided is to the best of my abilities factual / accurate.

Name Printed:_____

_____ _____

Signature **Date**