Intake Form

First Name:
Date of Birth:
Phone Number:
Address of Accident:

Last Name:
Date of Accident:
Time of Accident:

Were you the:
- Driver
- Passenger
- Other (please describe):

How was the weather:
- Snowing
- Raining
- Clear
- Windy

Where were you sitting in the vehicle?
- Front Driver Seat
- Front Passenger Seat
- Back Left Side Passenger
- Back Middle Passenger
- Back Right Side Passenger
- Not Applicable

Did you go to the hospital?
- Yes
- No

How long after the accident did you seek medical attention?
- Same day
- Next day
- Other:

If you were a pedestrian, please specify:
- Walking
- On a bike/scooter or other two-wheel transportation

Were you wearing a seat belt?
- Yes
- No

How did you get to the hospital?
- Ambulance
- Drove
- Not Applicable

Have You Ever Been Involved in an Accident?
- Yes
- No

How long ago were you involved in an accident?

Did you seek compensation?

What is the name and city of the facility where you received medical care?

Please describe what happened:

What are your current areas of pain? (Check all that apply)

- Neck
- Lower Back
- Upper Back
- Shoulder (Left)
- Shoulder (Right)
- Knee (Right)
- Knee (Left)
- Head
- Other (please describe):

Do you own a vehicle in your name?

- Yes
- No

What doctor are you currently treating with?

How many times a week are you seeing this doctor?

Who lives in your home? (Check all that apply)

- Mom
- Dad
- Sister
- Brother
- Wife
- Husband
- Uncle
- Aunt
- Other:

When you received medical care, did they perform any radiological tests?

- Yes
- No
- If yes, what tests were performed?

If you were a passenger, how are you related to the driver?

Did you lose any time from work?

- Yes
- No

Were you working at the time of the accident?

- Yes
- No

Was this during your lunch break?

- Yes
- No

If yes, how many days?

Notes (Special Items to be Reminded of):