Auto accident intake form

Today date: ___________________

Patient's Name: ____

Patient's (or the vehicle you were in) Insurance Company ____

Adjustor: _____________________________________

Phone # for adjustor:_______________________________________

Claim Number:_______________________________

Medpay Limit:_________________________________

1. What was the date and time of the accident?
2. Make and model of your vehicle:
3. What type of vehicle hit you (SUV, car, pickup, van)?
4. How many vehicles were involved in the accident?
5. What was the estimated damage to the vehicle you were in?
6. Number of people in your vehicle besides yourself:
7. What city & state did the accident occur in?
8. What Street or intersection where the accident occurred?
9. During and after the crash what happened to your vehicle? (circle all that apply)
   - kept going straight
   - kept going straight hitting a car in front
   - was hit by another vehicle
   - spun around
   - spun around & hit a stationary object (ie: tree, light pole)
   - hit a stationary object
10. Were you the: driver / front passenger / rear passenger
11. If driver, where was your right foot: gas/brake left foot: clutch
12. Impact came from the: front / rear / left / right / other (specify)
13. Direction you were heading: north / south / east / west
14. Direction they were heading: north / south / east / west
15. Direction you were facing: forward / right / left
16. Were you: surprised / aware the accident was going to occur
17. How did you feel right after:
18. Did you lose consciousness during the accident?
19. How was your head positioned during the accident? Straight ahead Rotated Right or Left Looking up or down
20. How was your torso positioned during the accident?
21. How were your hands positioned during the accident?
22. Did your head hit anything during the accident? Y/N describe: ____
23. Did your face hit anything during the accident? Y/N describe: ____
24. Did your shoulders hit anything during the accident? Y/N describe: ___________________________________
25. Did your chest hit anything during the accident? Y/N describe: _______________________________________
26. Did your hips hit anything during the accident? Y/N describe: ____
27. Did your knees hit anything during the accident? Y/N describe: _______________________________________

28. Did your feet hit anything during the accident? Y/N describe: ____________________________________

29. Did the car have airbags: yes / no

30. If yes..Did they inflate: yes / no

31. In relation to the base of your skull, where was the headrest? Above / below / at the base

32. Did you have your seatbelt on during the accident?

33. Did you slide out of your seatbelt during the accident?

34. What was damaged in your vehicle? (Circle all that apply)

- completely totaled	- mirror	- steering wheel	- dashboard
- front bumper	- rear bumper	- trunk	- seat frame
- back right door	- front left door	- front right door	- back left door
- windshield	- side window	- rear window	

35. Choose any items that dented inward

- floorboards - side door - dashboard

36. Choose any doors that would not open as a result of the accident

- front left - front right - rear left - rear right

37. Did the police arrive: yes / no

Was there a police report filed: yes / no

Were any traffic violations ordered: yes / no (if yes, to whom?)

38. At the time of the impact, how fast was your vehicle moving?

39. At the time of impact, how fast would you guess the other vehicle was moving?

40. Did you go to the hospital? Yes / no

If yes, name of hospital and when did you go: Immediately / next day / 2+ days

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(If no, don't need to answer 41-45) Why didn't you go?

41. How did get to the hospital? ambulance / private transportation

42. Were x rays taken at the hospital? If yes, which area was taken?

43. Were you hospitalized overnight?

44. Circle what you were prescribed (if anything) at the hospital

- pain medication - muscle relaxers - neck brace

45. Did you receive any stitches for any cuts at the hospital?

46. Is there anyone else that you have seen since the accident? DC / DO / DDS / primary care DR

47. Have you worked since the injury: yes / no- I can't due to my pain

If yes, any work restrictions: yes / no describe:

48. What are you not able to do anymore personally/ recreationally since the accident

49. Were there any witnesses: yes / no

50. Have you made any statements to any insurance company or anyone else?

51. Do you, or anyone, have photographs of the accident scene, automobiles, or your injuries: YES / NO

52. Were any vehicles towed from the scene? YES NO If YES, whose vehicle was towed? MINE OTHER

53. Do you believe that any of the following were defective and resulted in the accident itself or a worsening of your injuries? ROAD SIGNS ROADS TRAFFIC SIGNAL BRAKES SEAT BELT AIRBAG SEAT

54. Have you retained an attorney? Name and phone: ____

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Anything else that you would like to describe about the accident/event ______________________________

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Which of the following do you suffer from now, which you did not have prior to the accident?

(circle all that apply)

Headaches	Dizziness	Difficulty Concentrating
Long Term Memory Loss	Short Term Memory Loss	Amnesia
Blackouts Since Collision	Forgetting Numbers	Relationship Difficulties
Reading Problems	Writing Problems	Irritability
Apathy	Sleep Disturbances	Intolerance to Heat/Cold
Personality Changes	Attention Impairment	Emotional Difficulties
Blurred/Changed Vision	Sensitivity to Light	Missing Periods of Time
Intolerance to Alcohol	Speech Difficulties	Nausea/Vomiting
Impaired Comprehension/Learning	Extreme Thirst	Fatigue
Menstrual Irregularities	Tinnitus (ringing in ears)	Noise Intolerance
Loss of Coordination	Bumping Into Objects in View	Loss of Balance
Hearing Loss	Vertigo (spinning sensation)	Anxiety
Depression	Flashbacks to Accident	Nightmares
Unusual Behavior	Panic Attacks	Weight loss/gain ____lbs
Social Withdrawal/Anxiety in Crowds	Changes in taste/smell	Jaw/Chewing Pain
"Clunk" sound when moving neck	Thoughts of death/Suicide	Clicking in Jaw

Numbness/Tingling/Weakness in arms: Right Left Pain level 1-10_________

Numbness/Tingling/Weakness in Legs: Right Left Pain level 1-10_________