River City CHIROPRACTIC

Auto Accident

4311 W 6th Street, Ste C
Lawrence, KS 66049
785-856-0423

PERSONAL DATA:

Today's Date _____
Name (first middle last) _____ Date of Birth _____
Address, phone numbers, email, employment info, or emergency contact changed from initial intake form? ❑ Yes ❑ No

AUTOMOBILE INSURANCE INFORMATION:

Driver of the *vehicle you were in* _____ Auto Insurance _____
Policy # _____ Claim # _____
Auto Insurance Phone # _____ Name of Insurance Adjuster _____

Driver of *other vehicle* _____ Their Auto Insurance _____
Policy # _____ Claim # _____
Auto Insurance Phone # _____ Name of Insurance Adjuster _____

Have you retained an attorney? ❑ Yes ❑ No; If yes, Name_____ Phone _____

AUTOMOBILE ACCIDENT INFORMATION

Date of Accident _____ Time of Accident _____ This accident associated with work? ❑ Yes ❑ No
List the make, model & year of vehicle you were in: Make _____ Model _____ Year _____
List the make, model & year of the other car involved: Make _____ Model _____ Year _____
Did the police come to the accident scene? ❑ Yes ❑ No Is there a police report? ❑ Yes ❑ No

Where were you in the vehicle? ❑ Driver ❑ Front Passenger ❑ Rear Seat ❑ Other _____
Were you ❑ Aware or ❑ Surprised by the impact?
Did the air bag deploy? ❑ Yes ❑ No If yes, did it strike you? ❑ Yes ❑ No If yes, where? _____
Were you wearing a seat belt? ❑ Yes ❑ No If so, did you receive any injury or bruise from the seat belt? ❑ Yes ❑ No
Where were your hands? ❑ One on the wheel ❑ Both on the wheel ❑ Not Applicable
Did you lose consciousness upon impact? ❑ Yes ❑ No If so, for how long? _____
Was the seat adjustment altered by the accident? ❑ Yes ❑ No Was the seat broken by the accident? ❑ Yes ❑ No
Were you wearing a hat or glasses at time of impact? ❑ Yes ❑ No Were they still on after the accident? ❑ Yes ❑ No
Did any part of your body strike anything in the vehicle? ❑ Yes ❑ No If yes, describe _____
What was the approximate speed of your vehicle? _____ Speed of the other vehicle? _____
Did the impact to your vehicle come from: ❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other _____
During impact, were you facing: ❑ Right ❑ Left ❑ Forward ❑ Other _____

Describe the Accident _____
_____
_____

Did you go to the hospital? ❑ Yes ❑ No When? ❑ Immediately ❑ ___ Hours Later ❑ ___ Days Later
Which Hospital? _____ How did you get to the hospital? _____
How long did you stay in the hospital? _____ Did you receive: ❑ Collars ❑ Splints ❑ X-rays ❑ Medications
Follow-up Care recommendations: _____
Other doctor consulted after your accident: _____ Specialty _____
Date first seen _____ Type of Treatment _____ Treatment frequency _____
Have you been able to work since this injury? ❑ Yes ❑ No
Are your work activities restricted as a result of this injury? ❑ Yes ❑ No If yes, please explain _____
_____

Describe how you felt immediately after the accident _____
_____
_____

Adult Health History Cont.

River City CHIROPRACTIC

Indicate the Symptoms that are a result of this accident:

❑ Dizziness	❑ Numbness/Tingling	❑ Low Back Pain	❑ Back Stiffness	❑ Fatigue
❑ Fainting	❑ Difficult Sleeping	❑ Mid-Back Pain	❑ Neck Stiffness	❑ Irritability
❑ Irritability	❑ Headaches/Migraines	❑ Neck Pain	❑ Tension	❑ Memory Loss
❑ Jaw Problems	❑ Shortness of Breath	❑ Arm/Shoulder Pain	❑ Pinched Nerve	❑ Buzzing in Ear
❑ Stomach Upset	❑ Chest Pain	❑ Leg/Foot Pain	❑ Joint Pain	❑ Ears Ringing
❑ Nausea	❑ Loss of Balance	❑ Sciatica	❑ Sore Muscles	❑ Vision Problems

REASON FOR SEEKING CHIROPRACTIC CARE:

DESCRIBE MAJOR COMPLAINT _____

_____

Quality of Complaint ❑ Sharp ❑ Stabbing ❑ Burning ❑ Achy ❑ Dull ❑ Stiff & Sore ❑ Other

Does this complaint radiate/shoot to any areas of your body? ❑ No ❑ Yes -*Location* _____

Severity of Complaint ❑ None (0) ❑Mild (1-2) ❑Mild-Mod (2-4) ❑Moderate (4-6) ❑Mod-Severe (6-8) ❑Severe (8-10)

Frequency ❑ Always ❑ Hourly ❑ Daily ❑ Occasionally

Daily activities affected by this condition (Please check all that apply)

❑ Work/School	❑ Exercise/Sports	❑ Driving	❑ Walking	❑ Sleep
❑ Sitting	❑ Stairs	❑ Love Life	❑ Eating	❑ Other activities

Please explain _____

Aggravates Condition ❑ Sit ❑ Stand ❑ Walk ❑ Lying ❑ Sleep ❑ Overuse ❑ Other _____

Improves Condition ❑ Ice ❑ Heat ❑ Rest ❑ Movement ❑Stretching ❑ OTC Meds ❑ Other _____

DESCRIBE SECOND COMPLAINT _____

_____

Quality of Complaint ❑ Sharp ❑ Stabbing ❑ Burning ❑ Achy ❑ Dull ❑ Stiff & Sore ❑ Other

Does this complaint radiate/shoot to any areas of your body? ❑ No ❑ Yes -*Location* _____

Severity of Complaint ❑ None (0) ❑Mild (1-2) ❑Mild-Mod (2-4) ❑Moderate (4-6) ❑Mod-Severe (6-8) ❑Severe (8-10)

Frequency ❑ Always ❑ Hourly ❑ Daily ❑ Occasionally

Daily activities affected by this condition (Please check all that apply)

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Please explain _____

Aggravates Condition ❑ Sit ❑ Stand ❑ Walk ❑ Lying ❑ Sleep ❑ Overuse ❑ Other _____

Improves Condition ❑ Ice ❑ Heat ❑ Rest ❑ Movement ❑Stretching ❑ OTC Meds ❑ Other _____

DESCRIBE ADDITIONAL COMPLAINTS _____

_____

_____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize RCC to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance to Kansas' statutes.

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient or Guardian Signature _____ Date _____

Treating Doctor Signature _____ Date _____