Automobile Accident Intake Form

2237 North Commerce Parkway, Ste 2
Weston, FL 33326
Phone 954-888-6650 ● Fax 954-888-6645
www.westonmedicalhealth.com

CONFIDENTIAL PATIENT INFORMATION

Patient Name:____________________ **Date of Birth:**________ **Age:**______ **Date:** __________

Date of Accident:____________ **Time:** _____ **am / pm Claim Number:** __________________

Please describe the accident in your own words: ________________________

THE FOLLOWING PERTAINS TO YOU AND THE VEHICLE YOU WERE IN

Make and Model: ________________________ **Year:** __________

Vehicle type:
❑ Car ❑ Van ❑ Pickup ❑ Sports Utility Vehicle ❑ Station Wagon ❑ Commercial Truck ❑ Other __________

Vehicle size:
❑ Subcompact ❑ Compact ❑ Mid-size ❑ Large Car ❑ Small Pick-up ❑ Large Pick-up ❑ Small SUV ❑ Large SUV ❑ Other______

Your position in the vehicle:
❑ Driver ❑ Passenger: **If passenger:** ❑ Front Passenger ❑ Rear Passenger ❑ Third Row Passenger ❑ Other __________
Where in the row? ❑ Drivers Side ❑ Middle ❑ Passenger Side

Speed of your vehicle:
❑ Stopped ❑ Parked ❑ Slowing ❑ Accelerating ❑ Moving at approximately______miles per hour ❑ Other __________
If stopped or slowing, reason: ❑ Traffic Signal ❑ Stop Sign ❑ Pedestrian ❑ Parking ❑ Traffic

Collision type(s):
❑ Front Impact ❑ Rear Impact ❑ Side Impact: **Driver Side:** ❑ Front Side ❑ Middle ❑ Rear Side ❑ Other ________
Passenger Side: ❑ Front Side ❑ Middle ❑ Rear Side

THE FOLLOWING PERTAINS TO THE OTHER VEHICLE(S) INVOLVED

Make and Model:________________________ **Year:** __________

Vehicle type:
❑ Car ❑ Van ❑ Pickup ❑ Sports Utility Vehicle ❑ Station Wagon ❑ Commercial Truck ❑ Other __________

Vehicle size:
❑ Subcompact ❑ Compact ❑ Mid-size ❑ Large Car ❑ Small Pick-up ❑ Large Pick-up ❑ Small SUV ❑ Large SUV ❑ Other______

Speed of the other vehicle:
❑ Stopped ❑ Parked ❑ Slowing ❑ Accelerating ❑ Moving at approximately______miles per hour ❑ Other __________
If stopped or slowing, reason: ❑ Traffic Signal ❑ Stop Sign ❑ Pedestrian ❑ Parking ❑ Traffic

Collision Type(s):
❑ Front Impact ❑ Rear Impact ❑ Side Impact: **Driver Side:** ❑ Front Side ❑ Middle ❑ Rear Side ❑ Other ________
Passenger Side: ❑ Front Side ❑ Middle ❑ Rear Side

ROAD CONDITIONS AT THE TIME OF ACCIDENT

Road/Street Name(s):____________________ **City/State:** __________

Time of day:
❑ Full Daylight ❑ Dawn ❑ Dusk ❑ Night

Road conditions:
❑ Dry ❑ Damp ❑ Wet ❑ Snow Covered ❑ Ice Covered ❑ Patchy Ice/Snow ❑ Other __________

Visibility compromised?
❑ No ❑ Brightness ❑ Darkness ❑ Rain ❑ Snow ❑ Fog ❑ Other __________

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Patient Name:________________________ **Date:**__________ **Claim Number:** ____________________

THE FOLLOWING PERTAINS TO THE MOMENT OF IMPACT

At the moment of impact, you were:

❑ Totally unaware that the accident was impending ❑ Aware that the accident was impending ❑ Aware that the accident was impending and braced for it

If you were the driver of the vehicle, was your foot on the brake pedal?

❑ Yes ❑ No ❑ Knocked off by impact

Were both hands on the steering wheel?

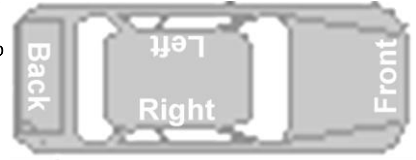
❑ Yes ❑ No: If no, which hand was on the steering wheel? ❑ Left ❑ Right

Please describe the position of your hand(s) on the wheel: ____________________

Were you wearing a seatbelt?

❑ Yes ❑ No If yes. what type? ❑ Shoulder ❑ Lap

On the diagram to the right, please mark the point(s) of impact on to your vehicle.



Was your vehicle equiped with air bags?

❑ Yes ❑ No If yes, was it/were they deployed? ❑ Yes ❑ No

Was your seat equiped with a headrest?

❑ Yes ❑ No If yes, what position was the headrest in: ❑ Low (below head) ❑ Middle (even with head) ❑ High (top of head)

Position of your HEAD at the time of impact?

❑ Facing straight ahead ❑ Tilted downward ❑ Tilted upward ❑ Turned to the left ❑ Turned to the right

Was your head jolted? ❑ Yes ❑ No

If yes, in which direction? ❑ Backward then forward ❑ Forward then backward ❑ To the left ❑ To the right ❑ Left then right ❑ Right then left

Position of your BODY at the time of impact?

❑ Facing straight ahead ❑ Tilted downward ❑ Tilted upward ❑ Turned to the left ❑ Turned to the right

Was your body jolted? ❑ Yes ❑ No

If yes, in which direction? ❑ Backward then forward ❑ Forward then backward ❑ To the left ❑ To the right ❑ Left then right ❑ Right then left

MISCELLANEOUS DETAILS

Did the police come to the accident site?

❑ Yes ❑ No Citations issued? ❑ None ❑ Yourself ❑ Driver of the vehicle you were in ❑ Driver of other vehicle

Has a police report been filed?

❑ Yes ❑ No

Damage to the vehicle you were in:

❑ Minimal ❑ Moderate ❑ Severe ❑ Totaled ❑ Not known Amount: $__________

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE:

Head:

❑ Steering wheel ❑ Headrest
❑ Air bag ❑ Front of seat
❑ Dashboard ❑ Back of seat
❑ Windshield ❑ Right door
❑ Rear view mirror ❑ Left door
❑ Console ❑ Right window
❑ Gear shift ❑ Left window
❑ Armrest

Torso:

❑ Steering wheel ❑ Headrest
❑ Air bag ❑ Front of seat
❑ Dashboard ❑ Back of seat
❑ Windshield ❑ Right door
❑ Rear view mirror ❑ Left door
❑ Console ❑ Right window
❑ Gear shift ❑ Left window
❑ Armrest

Left Arm:

❑ Steering wheel ❑ Headrest
❑ Air bag ❑ Front of seat
❑ Dashboard ❑ Back of seat
❑ Windshield ❑ Right door
❑ Rear view mirror ❑ Left door
❑ Console ❑ Right window
❑ Gear shift ❑ Left window
❑ Armrest

Left Leg:

❑ Steering wheel ❑ Headrest
❑ Air bag ❑ Front of seat
❑ Dashboard ❑ Back of seat
❑ Windshield ❑ Right door
❑ Rear view mirror ❑ Left door
❑ Console ❑ Right window
❑ Gear shift ❑ Left window
❑ Armrest

Right Arm:

❑ Steering wheel ❑ Headrest
❑ Air bag ❑ Front of seat
❑ Dashboard ❑ Back of seat
❑ Windshield ❑ Right door
❑ Rear view mirror ❑ Left door
❑ Console ❑ Right window
❑ Gear shift ❑ Left window
❑ Armrest

Right Leg:

❑ Steering wheel ❑ Headrest
❑ Air bag ❑ Front of seat
❑ Dashboard ❑ Back of seat
❑ Windshield ❑ Right door
❑ Rear view mirror ❑ Left door
❑ Console ❑ Right window
❑ Gear shift ❑ Left window
❑ Armrest

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Patient Name:____________________ **Date:**__________ **Claim Number:** ____________________

The following questions pertain to the time period IMMEDIATELY FOLLOWING the accident:

Did you lose consciousness?

❑ Yes ❑ No If yes, how long you were unconscious? ________________

Immediately following the accident, did you feel...?

❑ Dizzy ❑ Dazed ❑ Disoriented ❑ Weak ❑ Nervous ❑ Nauseated

Were you able to walk unaided?

❑ Yes ❑ No

Where did you go?

❑ Drove home ❑ Was driven home ❑ Drove to hospital ❑ Was driven to hospital ❑ Taken to hospital by ambulance
❑ Drove to work ❑ Was driven to work ❑ Drove to school ❑ Was driven to school ❑ Other:____________________

In what areas did you IMMEDIATELY feel pain?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low back						
❑ Pelvis						

In what areas did you experience lacerations (cuts) or contusions (bruises)?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low back						
❑ Pelvis						

In what areas did you experience symptoms on the day(s) FOLLOWING the accident?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low back						
❑ Pelvis						

The day after the accident, your symptoms were: ❑ Better ❑ Worse ❑ Same

Did you go to the hospital at any time since the accident?

❑ Yes ❑ No If yes, when?________________ Name of hospital? ________________________

At the hospital, what areas were x-rayed?

❑ Head	Shoulder	❑ Left	❑ Right	Hip	❑ Left	❑ Right
❑ Neck	Arm	❑ Left	❑ Right	Thigh	❑ Left	❑ Right
❑ Upper back	Elbow	❑ Left	❑ Right	Knee	❑ Left	❑ Right
❑ Mid back	Wrist	❑ Left	❑ Right	Calf	❑ Left	❑ Right
❑ Ribs	Hand	❑ Left	❑ Right	Ankle	❑ Left	❑ Right
❑ Chest	Fingers	❑ Left	❑ Right	Foot	❑ Left	❑ Right
❑ Abdomen	Buttock	❑ Left	❑ Right	Toes	❑ Left	❑ Right
❑ Low back						
❑ Pelvis						

Diagnoses given: ____

____

Treatment received: ____

Automobile Accident Intake Form cont.

Confidential Data

Patient Name:______________________________ **Date:**____________ **Claim Number:** ______________________

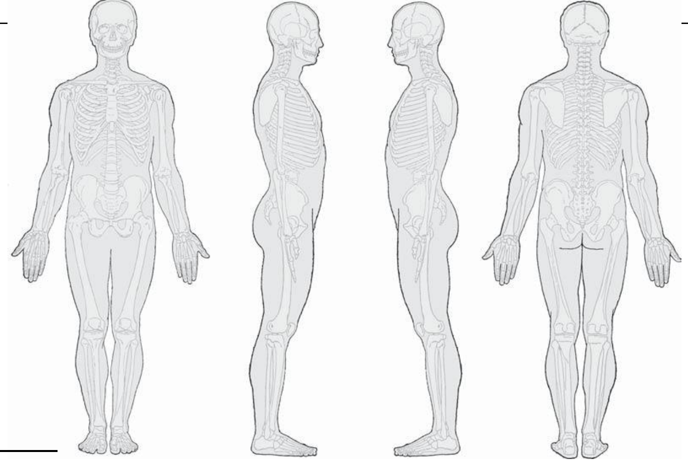
The following questions pertain to the symptoms/conditions you have experienced SINCE the accident:

Give a brief, detailed description of the problem(s) you are now experiencing: ______________________________

____

Using the diagram and key, please draw where you are experiencing symptoms:

1. Achy, Dull, Sore
2. Stiffness, Tightness
3. Sharp Stabbing
4. Sharp Shooting
5. Numbness, Tingling
6. Burning
7. Throbbing
8. Swelling
9. Snapping, Popping, Grinding
10. Other:______________



When did the condition(s) start? ______________________________

Please describe what happened: (if additional information to accident)______________________________

____

Your symptoms are: ❑ Constant - if constant, are they truly present 24hrs/day? ❑ Yes ❑ No

❑ Intermittent - if intermittent, how often do you feel them?_______x/day How long do they last?____________

- associated with any activities/positions/etc?______________________________

Compared to onset, are your symptoms: ❑ Better ❑ Worse ❑ Same

Do your symptoms prevent you from getting to sleep? ❑ Yes ❑ No **Wake you at night?** ❑ Yes ❑ No

Have you ever had the problem(s) before? ❑ Yes ❑ No If so, please explain:______________________________

____

What makes your condition(s) better? (e.g. positions, activities, heat/ice, medications, etc.)______________________________

____

Are your activities of daily living affected? (e.g. difficulty performing work duties, getting dressed, etc.) ❑ Yes ❑ No If so, please explain:__________

____

Please describe any other conditions/symptoms you feel are related to this complaint: ______________________

____

Have you ever been treated for this condition previously: ❑ Yes ❑ No If so, please complete below:

Date	Practitioner	Facility	Diagnosis	Treatment Provided