Motor Vehicle Accident Initial Intake Form

Patient Name_____ Today's Date_____ Date of Birth_____

Date of Injury: _____Claim #_____Insurance Co._____

Adjuster's Name: _____ Adjuster's Phone #: _____

Have you retained an attorney? Y N Attorney name and contact info._____

ACCIDENT DETAILS

You were: driver front passenger rear passenger
pedestrian bicyclist

Your vehicle year/make/model:_____

Estimated speed at time of accident:

stopped slowing accelerating

Location/street:_____

Direction of travel: N S E W

Impact came from: front rear right left other

Other vehicle year/make/model:_____

Approximate speed of other vehicle_____

Time of day_____

Road conditions: dry damp wet icy snow

Body position at time of impact:

Head: Forward R L up down

Body: Forward R L up down

Lap belt: on off

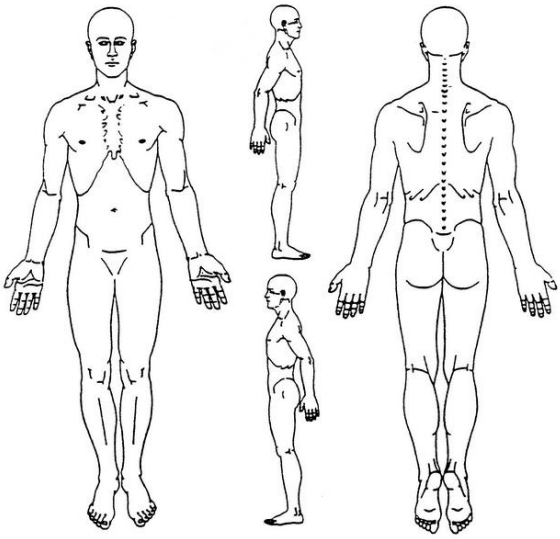
Shoulder harness: on off

Aware of impending impact? Y N

Airbag deployed? Y N Did airbag hurt you? Y N

Please sketch a diagram of the accident below

Please mark areas of pain, tightness or symptoms



DURING THE ACCIDENT

Did your body strike any other parts of the inside of your vehicle? Y N If yes, describe?_____

Did your vehicle strike any other objects after initial impact? Y N If yes, describe?_____

Was your vehicle pushed in any other direction by the impact? Y N If yes, describe?_____

Were you wearing a hat or glasses before impact? Y N If yes, were they still on after impact? Y N

Did you strike your head? Y N If yes, on what?_____Did you lose conciousness? Y N If yes, how long?_____

Did police respond? Y N Was accident report filed? Y N Did EMS respond? Y N

Estimated property damage to your vehicle $_____Estimated damage to other vehicle: MILD MODERATE MAJOR

AFTER THE ACCIDENT

Describe how you felt immediately after the accident:_____

Did you receive medical attention after the accident? Y N If yes, where were you seen?_____

How long after the accident did you seek care?_____How did you get there? EMS OTHER_____

Name of hospital or doctor?_____

Was medication prescribed? Y N _____Xrays?_____MRI?_____Lab?_____

PLEASE DESCRIBE ANY PRIOR INJURY TO CURRENT INJURED AREA

_____

CURRENT CONDITIONS-this area for office use only!!

1. Constant/Intermittent Dull/Achy/Sharp/Electrical/_____

Body Part/Area _____
Onset_____Temporal_____
Severity: Now_____Avg_____Worst_____
Provocative:_____
Palliative:_____

2. Constant/Intermittent Dull/Achy/Sharp/Electrical/_____

Body Part/Area _____
Onset_____Temporal_____
Severity: Now_____Avg_____Worst_____
Provocative:_____
Palliative:_____

3. Constant/Intermittent Dull/Achy/Sharp/Electrical/_____

Body Part/Area _____
Onset_____Temporal_____
Severity: Now_____Avg_____Worst_____
Provocative:_____
Palliative:_____

4. Constant/Intermittent Dull/Achy/Sharp/Electrical/_____

Body Part/Area _____
Onset_____Temporal_____
Severity: Now_____Avg_____Worst_____
Provocative:_____
Palliative:_____

5. Constant/Intermittent Dull/Achy/Sharp/Electrical/_____

Body Part/Area _____
Onset_____Temporal_____
Severity: Now_____Avg_____Worst_____
Provocative:_____
Palliative:_____

6. Constant/Intermittent Dull/Achy/Sharp/Electrical/_____

Body Part/Area _____
Onset_____Temporal_____
Severity: Now_____Avg_____Worst_____
Provocative:_____
Palliative:_____

PAST MEDICAL HISTORY (Circle all that apply)						
Neuro	Migraine	Tingling feet/hands	Seizures	Shingles	Sciatica	Stroke
Endocrine	Diabetes	Hepatitis	Menopause	High cholesterol	Obesity	
Respiratory	Asthma	Emphysema	Pneumonia	Seasonal allergy	TB	Sinusitis
Cardiac	Heart attack	High blood pressure	Murmur	Arrhythmia	Stent	Valve disorder
GI	GERD	Hemorrhoids	IBS	Gluten sensitivity	Constipation	Gallstones
Vascular	Blood clots	Atherosclerosis	Embolism	Aneurysm	Anemia	Dizziness
Ortho	Osteoarthritis	Fibromyalgia	Osteoporosis	Gout	Hernia	Disc injury
GU	Kidney stones	Bladder infections	Nephritis	Menstrual disorder	Prostatitis	STD
Psych	Depression	Anxiety	Panic	OCD	Bipolar	Addiction
Immune	Rheumatoid	HIV	Thyroiditis	MS	Psoriasis	AS
Cancer	Type and treatment?					
Other	Any other conditions not mentioned?					

FAMILY HEALTH HISTORY-List any known cancers, causes of death, immune disorders, heart disease, etc. in your:

Parents:_____ Grandparents:_____

Aunts/Uncles:_____ Grandparents:_____

Brothers/Sisters_____ Grandparents:_____

SOCIAL/LIFESTYLE HISTORY

Marital Status_____Children (include ages)_____Who do you live with? _____

Do you feel safe in your home? Y/N _____Highest education level_____

Employer_____How long?_____

Missed work d/t this accident? (details)_____

Sport/Exercise_____

Missed exercise d/t this accident? (details)_____

Sleep quality_____ Special diet?_____

Tobacco_____pk/day___yrs Alcohol intake and frequency_____drinks, per _____

PATIENT: "My signature below reflects that the above information is true and correct to the best of my knowledge."

Patient signature_____Date_____

(If appropriate) Parent or legal guardian_____Date_____

OTHER CARE FOR PRESENT CONDITIONS Please list other healthcare providers you've seen for this condition (please provide contact information/address)

Primary Care Physician:_____

Specialist:_____

Chiropractor:_____

Physical therapist:_____

Other:_____

Other:_____

PRIOR SURGERIES (list dates for each)

_____Date_____ _____Date_____

_____Date_____ _____Date_____

CURRENT MEDICATIONS & SUPPLEMENTS

_____

_____

_____

Tabor Village Wellness
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IRREVOCABLE DOCTOR'S LIEN AND ASSIGNMENT OF RIGHT TO RECOVERY

In consideration and exchange for not having to immediately pay a debt owed and in consideration for receiving future care at or by the clinic and doctors whose letterhead this document is printed (hereinafter "Clinic"), I, the undersigned, hereby assign and convey to the Clinic a legal and equitable interest in any and all causes of action or rights of recovery I may have arising out of that certain accident or injury-producing event which occurred on or about the ____ day of _____, 2____, to the full extent of the cost and treatment provided or to be provided to me by the Clinic.

I hereby authorize and direct my attorneys(s) to hold in trust, and to pay directly to the Clinic such sums as may be due and owing the Clinic for treatment and other professional services rendered me both by reasons of this accident and by reason of any other bills that are due the Clinic and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately pay and protect the Clinic. I hereby further give, grant, and convey a lien on my case to the Clinic against any and all proceeds of any and all causes of action, settlements, judgments, or verdicts which may be paid to or through my attorney, or myself, as the result of the injuries or conditions for which I have been treated by the Clinic.

I fully understand that I am directly and fully responsible to the Clinic for all bills incurred for services rendered to me and that this agreement is made solely for the Clinic's additional protection and in consideration for the Clinic's delay in receiving payment. I further understand that payment for services rendered by the Clinic is not contingent on any settlement, judgment, or verdict by which I may eventually recover. I am personally responsible for my bills, regardless of the outcome of any legal claim or case.

I fully understand if my attorney(s) does/do not protect the Clinic's interest from any settlement received, the Clinic may require me to make payments on a current basis plus interest at 1.5% per month. The Clinic may also bring a cause of action against me and/or my attorney(s) for failing to honor this binding and irrevocable agreement.

I further understand and agree that the Clinic is not responsible for paying any of my attorney's fees related to my legal claim and the Clinic has no obligation to pay my attorney(s) and attorney fees for honoring this agreement between me and the Clinic.

"I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT, AND I AM VOLUNTARILY SIGNING THIS DOCUMENT. I AM DIRECTING MY ATTORNEY(S) TO PROTECT THE CLINIC'S AND DOCTOR'S INTEREST AT TIME OF SETTLEMENT, AND I AM ASSIGNING AND CONVEYING CERTAIN LEGAL RIGHTS OVER TO THE CLINIC. I ALSO KNOW I MAY NOT REVOKE THIS AGREEMENT AT ANY TIME WITHOUT PRIOR WRITTEN AUTHORIZATION FROM THE CLINIC. I UNDERSTAND THAT, AMONG OTHER THINGS, THIS IS A BINDING AND ENFORCEABLE CONTRACT, ASSIGNMENT, AND LIEN."

_____	_____	_____
Patient Name (Print)	**Patient Signature**	**Date**