Back-2-Back Chiropractic, P.C.
3000 NW Stucki Place, Suite 180
Hillsboro, OR 97124
T (503) 726-2225 **F** (503) 726-2224

Automobile Accident Intake Form

Confidential Data

Patient Name: ____________________ **DOB:** (m/d/y)__________ **Age:** ______ **Date:** ________

Date of Accident: ____________________ **Time:** __________ am / pm **Claim Number:** ________

Please describe the accident in your own words: ______________________________

____

____

____

The following questions pertain to YOU and the vehicle you were in:

Make and Model: ______________________________ **Year:** __________

Vehicle type:
❑ Car ❑ Van ❑ Pickup ❑ Sports Utility Vehide ❑ 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, were you: ❑ 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 questions pertain to the OTHER vehicle(s) involved:

Make and Model: ______________________________ **Year:** __________

Vehicle type:
❑ Car ❑ Van ❑ Pickup ❑ Sports Utility Vehide ❑ 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 the 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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Automobile Accident Intake Form cont.

Confidential Data

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

The following questions pertain to the moment of IMPACT of the accident:

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

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

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

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

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

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

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

Please continue to next page...

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Automobile Accident Intake Form cont.

Confidential Data

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: ____

____

Please continue to next page...

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Automobile Accident Intake Form cont.

Confidential Data

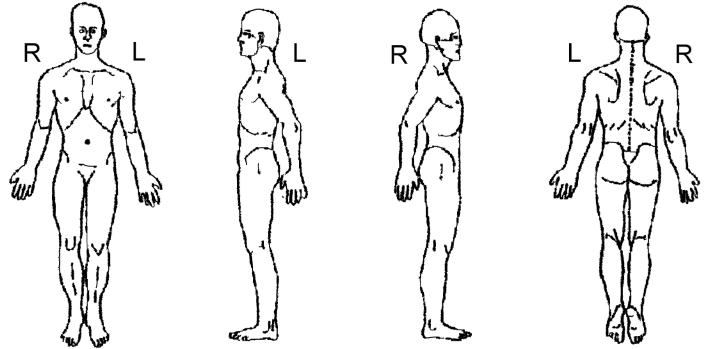
Patient Name: ______________________ **Date:** __________ **Claim Number:** ______________

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. Achey, 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? ______________ **Onset of symptom(s) was:** ❑ Immediate ❑ Gradual

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

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

Please name your conditions/areas: 1: ______ 2: ______ 3: ______

Please rate the severity of your pain/ symptoms: (0=no pain : 10=unberable)

	1	2	3
At Onset >>>	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Average >>>	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Percentage of time you experience symptoms: ______% ______% ______%

What makes your condition(s) worse? (e.g. positions, activities, etc.)______________________

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

Please continue to next page...

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Automobile Accident Intake Form cont.

Confidential Data

Patient Name: ______________________ **Date:** __________ **Claim Number:** ______________

The following questions pertain to your MEDICAL HISTORY and GENERAL HEALTH:

Please list any serious illnesses you have had: ____

Please complete the following table describing any hospitalizations or surgeries:

Date	Practitioner/Facility	Reason/Diagnosis	Treatment Provided

Please describe any major accidents/traumas/injuries you have had and the treatment received: ______________________

Please list any medications you are presently taking: (include vitamins)

Medication	Dose	Reason

Please list any allergies: ______________________

When was your last physical exam? ______________________

Any pertinent results? ______________________

Have you seen a chiropractor before? ❑ Yes ❑ No

If so, who? ______________________

What for? ______________________

Please describe any medical conditions that run in your immediate family: (e.g. heart disease, cancer, etc.; include siblings, parents, and grandparents)

Relative(s)	Conditions	Relative(s)	Conditions

Do you do any regular exercise? ❑ Yes ❑ No If so, please describe: (what, how much, how often) ______________________

Please describe your diet: ______________________

How often do you eat the following? (x/day or wk) ________ Fruits ________ Vegetables ________ Dairy ________ Meat ________ Sweets

How much water do you drink ? ________ glasses/day **How much coffee?** ________ cups/day

Do you drink alcohol? ❑ Yes ❑ No If so, how much? ________ **Do you smoke?** ❑ Yes ❑ No Packs/day ________ How long? ________

How often do you have a bowel movement? ________ x/day or wk Recent Changes? ❑ Yes ❑ No Describe: ______________

Any recent changes in bladder function? (freq, urgency, difficulty start/stop) ❑ Yes ❑ No Describe: ______________

Women Only: **Do you have a menstrual cycle?** ❑ Yes ❑ No If so, when was your last cycle? ______________

If not, please explain: ______________

Are you presently on a contraceptive medication? ❑ Yes ❑ No If so, what? ______________

Are you, or could you be pregnant? ❑ Yes ❑ No If so, estimated due date? ______________

By signing below, I certify that the information in this document is full and complete to the best of my knowledge:

Patient Signature: ______________________ **Date:** ______________
(parent/guardian if under 18)

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Patient Registration Form

Confidential Data

PERSONAL INFORMATION

Mr. / Mrs. / Miss / Ms / Dr. _______________ / / _____

Patient Name (first, middle initial, last) Patient DOB (m/d/y) Age

Patient Address City State Zip

Home Phone Work Phone Cell Phone Email Address

Social Security # Drivers License (State, Number)

Gender : ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Other

Your Occupation Your Employer

Referred by: ❑ Friend ❑ Family Member ❑ Physician Name: ______________________

❑ Website ❑ Advertisement ❑ Other: ______________________

Payment for Services will be by: ❑ Cash ❑ Check ❑ Credit Card ❑ Health Insurance ❑ Automobile Insurance ❑ Workers Compensation

INSURANCE INFORMATION

Name of Insurance Co. Insurance Co. Phone Number

Insurance Co. Address City State Zip

Insurance Co. Policy # Group # Plan # Policy Effective Date

Claim Rep. (if Auto Insurance) Claim Rep. Phone Number/Ext. Claim #

Are you covered by more than one insurance company? ❑ No ❑ Yes Name: ______________________

PRIMARY CARE PHYSICIAN

Name of Physician Name of Practice Tel

Practice Address City State Zip

IN CASE OF EMERGENCY

Name of Relative or Friend Relationship to Patient Home Phone Cell Phone

The above information is true to the best of my knowledge. I authorize Back-2-Back Chiropractic to contact my insurance company as necessary and all benefits to be paid directly to Back-2-Back Chiropractic. I understand that I am responsible for any balance. I also authorize Back-2-Back Chiropractic or my insurance company to release any information required to process my claim.

Patient Signature (guardian if under 18) Date