AUTOMOBILE / INJURY INTAKE FORM

What was the date of the accident/injury? _______________________________________

Where were you in the vehicle? □ Driver's seat □ Front Passenger □ Rear Passenger

Where was the impact to the vehicle? □ Rear □ Front □ Passenger □ Driver (check all that apply)

Did you strike anything in the vehicle? □ Yes □ No

If yes, which body part was struck? □ Head □ Shoulder □ Knee □ Arm □ Leg □ Chest □ Other ____________

What did your body part strike in the vehicle? □ Windshield □ Dashboard □ Center Console □ Door □ Other ____________

Did you go to the Hospital? □ Yes □ No □ If Yes, which hospital? __________________________

Did they take x-rays? □ Yes □ No

Did they prescribe any medication? □ Yes □ No □ If Yes, which medication(s)? __________________________

Have you seen any other doctors for this injury? □ Yes □ No □ If Yes, which doctor(s)? __________________________

Please check the box(es) that describe your current condition:

□ Headache □ Lower back pain □ Hip pain □ Neck pain □ Chest pain □ Leg pain □ Mid back pain
□ Numbness/Tingling □ Knee Pain □ Shoulder Pain □ Arm pain □ Foot/ankle pain □ Between shoulder blades
□ Wrist/hand pain □ Other __________________________

What makes the pain worse? □ Bending □ Lifting □ Getting up □ Laying □ Walking □ Sitting □ Driving □ Working
□ Other __________________________

What have you been doing to decrease the pain? □ Tylenol □ Ibuprofen (Advil, Motrin) □ Ice □ Heat □ Rest □ Stretching
□ Other medication (please list) __________________________

How would you describe the pain? (Check all that apply) □ Dull □ Achy □ Sharp □ Burning □ Throbbing □ Tingling
□ Numb □ Pins and Needles □ Other __________________________

Does the pain travel or radiate to an extremity? □ Right □ Left □ Arm □ Leg
□ Stops at the elbow □ Goes to the fingers (whole arm) □ Only in fingers
□ Stops at the knee □ Goes to the toes (whole leg) □ Only in foot

Is the pain worse □ in the evening □ in the morning □ during the day □ during work □ Other __________________________

Have you had any previous injuries to the spine? □ Yes □ No
□ If yes, □ Fracture □ Surgery □ Auto Accident □ Other __________________________

Please describe injury __________________________

Have you missed any work as a result of your current condition? □ Yes □ No

FOR WOMEN ONLY — Is it possible you are pregnant? □ Yes □ No □ Date of last menstrual period __________________________