Auto Accident Intake Form

Date:___/____/______

Name____AGE_________ DOB______/______/_______

Address____City___________________ST_____Zip_______________

SS#______-_____-________Home Phone__________________ Cell ___________________ Marital Status: M S D W

Electronic Appointment Reminders: ☐ Yes ☐ No (**Phone Carrier**:__________)**Email:**__________________________

Auto Insurance ____Policy #________________________________

Address ____City_______________ST_____Zip_____________

Other Parties Insurance_____________________________________Policy #________________________________

Address ____City_______________ST_____Zip_____________

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

Date of Auto Accident ______/______/________Time______________________Claim#_____________________

Make and Model:____Year:__________

Vehicle type: ☐ Car ☐ Van ☐ Pickup ☐ Sports Utility Vehicle ☐ Station Wagon ☐ Commercial Truck ☐ Other__________

Collision type(s): ☐ Front Impact ☐ Rear Impact ☐ Side impact ☐ Driver Side ☐ Front Side ☐ Other_________

Your position in the vehicle: ☐ Driver ☐ Passenger:

If passenger, were you: ☐ Front Passenger ☐ Rear Passenger

Where in the row? ☐ Third Row Passenger ☐ Middle ☐ Drivers Side ☐ Passenger Side ☐ Other_______________

The following questions pertain to the OTHER vehicle(s) involved:

Make and Model:____Year:__________

Vehicle type: ☐ Car ☐ Van ☐ Pickup ☐ Sports Utility Vehicle ☐ Station Wagon ☐ Commercial Truck ☐ Other______________

Collision type(s): ☐ Front Impact ☐ Rear Impact ☐ Side Impact ☐ Driver Side ☐ Front Side ☐ Other__________

Did the police come to the accident site? ☐ Yes ☐ No Has a police report been led? ☐ Yes ☐ No

Damage to the vehicle you were in: ☐ Minimal ☐ Moderate ☐ Severe ☐ Totaled ☐ Not known

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

Were you wearing a seatbelt? ☐ Yes ☐ No ☐ Shoulder ☐ Lap

Was your vehicle equipped with air bags? ☐ Yes ☐ No *If yes, was it/were they deployed?* ☐ Yes ☐ No

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

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

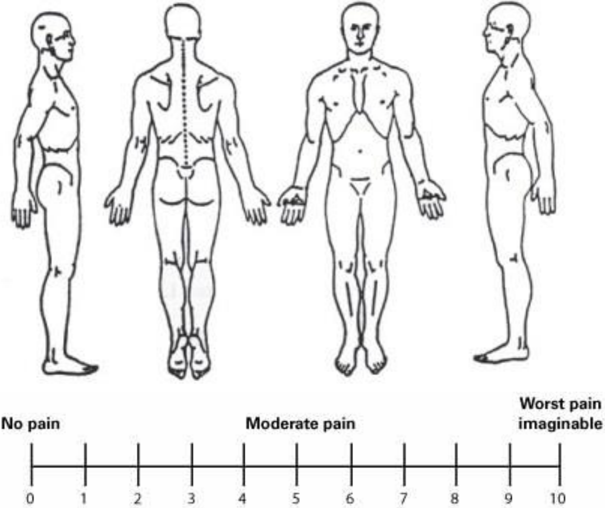
Did you go to the hospital after the accident? ☐ Yes ☐ No ☐ Other ____

Doctor____

Type of care given? ____How often? ___________________

Place appropriate symbols to mark the areas of discomfort

XXX BURNING (BU)
(((ACHING PAIN (AC)
OOO PINS & NEEDLES (PI)
: : : NUMBNESS (NU)
/ / / SHARP PAINS (SH)



For Office Use Only

☐ Constant ☐ Come/Go ☐ Better
☐ Worse ☐ Same

Better:		Worse:
__________	AM	__________
__________	MIDDAY	__________
__________	PM	__________

When did the condition(s) start? ☐ Right Away ☐ Next day
☐ Few days later ☐ Other ____

Symptom you have notice since the accident:

☐ Headaches/Migraines	☐ Neck Pain	☐Shoulder Pain	☐ Mid-back Pain	☐Low Back Pain
☐ Depression	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking	☐Dizziness	☐ Fatigue
☐ Cold Hands/Feet	☐ Fever	☐ Numbness/Tingling	☐ Loss of Smell	☐ Chest Pain
☐Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems	☐ Pinched Nerve	☐ Loss of Sleep
☐ Loss of Balance	☐ Light Bothers Eyes	☐ Nervousness	☐ Vision Problems	☐ Tension
☐ Sleeping Problems	☐ Urinary Problems	☐ Paralysis	☐ Fainting	☐ Pins/Needles ☐
Stomach Upset	☐ Irritability	☐ Loss of Memory	☐ Buzzing in Ears	☐ Sciatica
☐ Upper Back Pain	☐ Difficulty Swallowing	☐ Head Feels Heavy	☐ Sinus Pain	☐ Sore Muscles

☐ Other ____
____
____

Was there any surgery? ☐ Yes ☐ No If YES what? ____

Were you able to return to work after the accident? ☐ Yes ☐ No *If YES*: When:_____/_____/_______

Any restrictions? ____

Were you disabled after the accident? ? ☐ Yes ☐ No If YES date of disability: _____/______/_______
____
____

Was there any accident prior to the current one? ? ☐ Yes ☐ No

If YES give dates: 1. ____/_____/______ 2.____/_____/______

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

Please explain briefly how the accident happened:

____

____

____

____

Attorney Information

Attorney Name ____ Practice Name ____________________________________

Address ____City________________________ST_____Zip___________

Phone___________________EXT___________Fax__________________Email____________________________________

Auto Accident Financial

You will be responsible for bringing in insurance information regarding your auto accident. Present all forms (medical/accident report) and adjustor's information that pertain to the incident. You are responsible for informing your insurance ahead of time. Most payments will come directly to us but if not, you will be responsible for full payment at time of service. An Attorney Lien will be singed on the start of your care in auto accidents. If a third party insurance is involved, you will pay services on the same day as care. All Doctor's notes will be submitted along with billing. Whatever expenses that are not paid by the insurance will be your responsibility. If you wish to submit later to your personal health insurance after we have billed the initial auto insurance, we will be more than happy to supply information needed to bill yourself.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL THE ABOVE STATEMENT'S ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORIZATION FOR THESE PROCEDURES TO BE PERFORMED. I ALSO GIVE PERMISSION FOR MY CASE TO BE USED FOR RESEARCH PURPOSES IF IT SO APPROVED.

Patient **Name** ____ ___ Date ______/_______/_______

Patient/Guardian **Signature** ________________________________

OFFICE PERSONAL: DATE:____/____/_______

NAME:____________________________________

SIGNATURE:________________________________

Please fill out any boxes that apply below:

MEDICAL REPRESENTATIVE INFORMATION

I have ____ representative that handles my Medical and Financial accounts.

Phone:_______________________ Address:_____________________________City______________ST____Zip_______

(AUTHORIZATION TO TREAT A MINOR) (ONLY PARENT OR GUARDIAN SIGN)

I _______________________________________ HEREBY AUTHORIZE DR STEVEN J FELICIJAN TO ADMINISTER CHIROPRACTIC CARE AS HE DEEMS NECESSARY TO MY SON/DAUGHTER ______________________________________.

DATED AT PARDEEVILLE, WI ON THIS ___________DAY OF ________________________, 20_______.

SIGNED: ____