ASPEN
CHIROPRACTIC CENTER

Auto Injury Intake Form

Patient Name:_____

Date of Birth:_____ Today's Date:_____

Date and Time of Accident:_____

Employer:_____

What is your current employment status?

- ☐ I resumed my same job and duties
- ☐ I resumed my same job with lighter duties
- ☐ I resumed alternate duties in the same industry
- ☐ I changed industry
- ☐ I have not resumed work

What kind of work is involved at your place of employment?

☐ Office and clerical

- ☐ Light labor
- ☐ Moderate Labor
- ☐ Heavy labor

Were you a driver or a passenger?

- ☐ Driver
- ☐ Passenger - Circle one: Front Seat Left Rear Seat Right Rear Seat
- ☐ Motorcycle Rider
- ☐ Motorcycle Passenger
- ☐ On a Bicycle
- ☐ Pedestrian

What was the year, make, and model of the vehicle you were in?

_____

Was your vehicle moving or stopped?

- ☐ Proceeding along
- ☐ Accelerating
- ☐ Slowing down
- ☐ Making a right turn
- ☐ Making a left turn
- ☐ Stopped
- ☐ Stopped at red light
- ☐ Stopped at stop sign
- ☐ Stopped at intersection
- ☐ Stopped in traffic
- ☐ Parking

Patient Name:_____

What was the estimated speed of your vehicle?_____mph.

What part of your vheicle did the other car hit?

☐ Rear ☐ Front ☐ Left Front ☐ Right Front ☐ Left Rear ☐ Right Rear
☐ Front Driver Side ☐ Rear Driver Side ☐ Front Passenger Side ☐ Rear Passenger Side

What was the make and model of the vehicle that hit you?

_____

What was the estimated speed of the other vehicle?_____mph.

What was the size of the vehicle that struck you?
☐ 25% larger than ☐ 50% larger than ☐ 75% larger than
☐ 25% smaller than ☐ 50% smaller than ☐ 75% smaller than ☐ Same size as

How was the visibility at the time of the collision?
☐ Poor ☐ Fair ☐ Good

What were the road conditions at the time of impact?
☐ Clean and Dry ☐ Wet ☐ Icy

Did you see the collision coming?
☐ Anticipated the collision ☐ Did not anticipate the collision

Were you braced for impact?
☐ Was braced for the impact ☐ Was not braced for the impact

Were you wearing a seatbelt?
☐ Was wearing a seatbelt with a shoulder harness ☐ Was not wearing a seatbelt
☐ Was wearing a seatbelt without a shoulder harness

Did you sustain any bruises from the seatbelt? ☐ No ☐ Yes, please list location

_____

How was the top of your head rest positioned?
☐ Even with the top of the head ☐ Even with the bottom of the head
☐ Even with the middle of the neck ☐ Even with the upper back

What was your head position at the time of impact?
☐ Facing straight forward ☐ Flexed downward ☐ Extended upward
☐ Turned to the left ☐ Turned to the right

Patient Name:_____

What was your hand position during the accident?
☐ Both hands on the steering wheel ☐ The right hand on the steering wheel
☐ The left hand on the steering wheel

What was your body position at the time of impact?
☐ Good ☐ Slumping forward ☐ Lying down sideways in the back seat
☐ Reclining in front seat ☐ Reaching onto the floorboard ☐ Turning around in my seat
☐ Leaning sideways

Was there any loss of consciousness? ☐ Yes ☐ No

Did the airbags deploy? ☐ Yes ☐ No

Were any objects thrown around inside of the car? ☐ Yes ☐ No

If yes, please list:_____

Did any part of your body strike the inside of the car? ☐ Yes ☐ No

If yes, please list:_____

Did you have the brakes applied at the time of impact? ☐ Yes ☐ No

Did police arrive at the scene? ☐ Yes ☐ No

Was a police report filled out?
☐ Yes, already filled out ☐ No, was not filled out ☐ Will be filled out

Who received a ticket?
☐ You ☐ The driver of the other vehicle ☐ You AND the driver of the other vehicle

Did EMTs/Paramedics arrive at the scene? ☐ Yes ☐ No

Were you taken to the hospital by ambulance? ☐ Yes ☐ No

What aid/support was used after the accident? Ex: Neck brace, crutches, medication, etc.)

_____

What aid/support is currently being used? Ex: Neck brace, crutches, medication, etc.)

_____

How did your vehicle leave the scene?
☐ Towed ☐ Driven away

How did the other vehicle leave the scene?
☐ Towed ☐ Driven away

What was the estimated cost of damage to the vehicle you were in? $_____

Patient Name:_____

Please describe the accident in you own words:

_____

_____

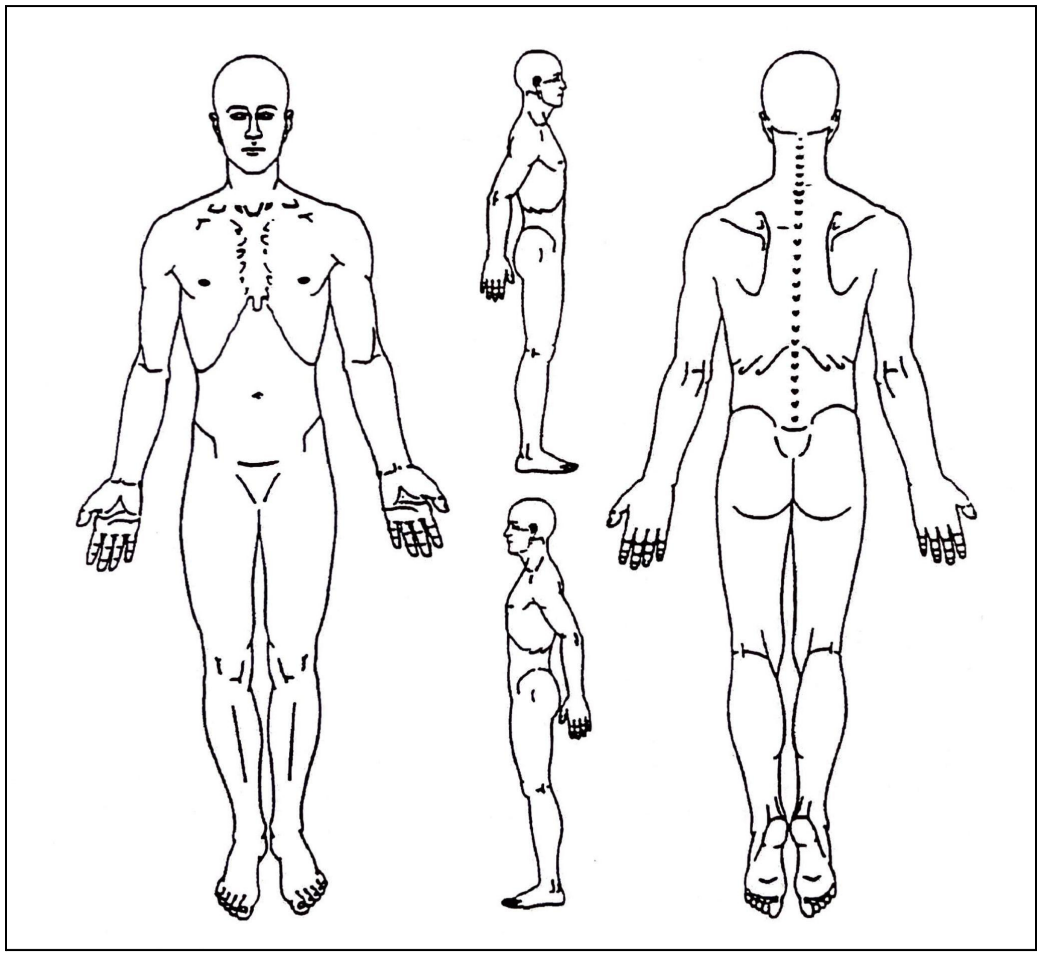
_____

_____

_____

_____

Please mark an “X” in all areas you are having pain.



Please indicate your level of pain from 0-10 for the following regions of your neck and back.

0 = No Pain, 10 = Worst possible pain

Neck:_____ Upper Back:_____ Mid Back:_____ Lower Back:_____