Desert Shadows Chiropractic and Wellness
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Personal Injury Intake Form

Name____ Date______________

Date of injury: ___/____/_____/ Time: __________ AM / PM
Where did the injury occur?______________________________________

Please describe the injury in your own words?______________________________________
____
____

Was there anything in particular that you think caused the injury: example: wet floor
Please describe:______________________________________
____

Immediately after the accident, were you: ☐ Conscious ☐ Dazed ☐ Unconscious
If dazed or unconscious, how long?______________________________________

Did anyone witness your injury? ☐ Yes ☐ No
Who?______________________________________
Did you report the injury to anyone? ☐ Yes ☐ No Who?______________________
Was the report: ☐ Written ☐ Verbal

Did you go to the hospital? ☐ Yes ☐ No If yes: ☐ Right after the injury ☐ Next day ☐ Other______________________________________
If yes, how did you get there? ☐ Ambulance ☐ Other______________________
If by ambulance, did the ambulance attendants place you in a: ☐ Neck Brace ☐ Back Brace ☐ Other______________________________________

List any medication or medical supplies given?______________________
Did you have X-rays taken at the hospital? ☐ Yes ☐ No

If you went to the hospital or saw another doctor, please answer the following:
Hospital Name______________________ Doctor Name______________________
Diagnosis______________________ Treatment received______________________

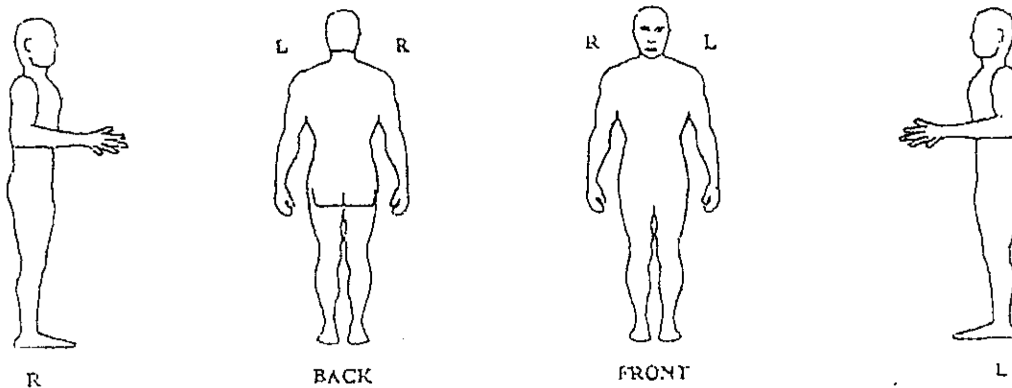
What type of work do you do?______________________________________
Requirements?______________________________________
Have you lost any days of work because of this injury? ☐ Yes ☐ No
If yes, date(s)______________________________________

Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ Maybe
If yes, please give name and address:______________________________________

Patients Signature______________________________ Date___/___/___/

Areas of Complaint

Place "X's" on the areas where you have pain and draw lines to where it radiates:



Did you have any of the above complaints before your injury? Yes No

Are you experiencing any of the following since your injury? (mark all that apply)

___Headaches	___Blurry vision	___Dizziness/Loss of balance	___Digestive Problems
___Neck Pain	___Rapid heartbeat	___Blood/Lymph disorders	___Shoulder Pain
___Anxiety	___Urinary difficulties	___Indigestion	___Elbow Pain
___Fatigue	___Skin problems	___Breathing Problems	___Wrist/Hand Pain
___Sore throat	___Memory lapses	___Hot/Cold Flashes	___Upper Back Pain
___Knee Pain	___Chest Pain	___Low Back Pain	___Weight Loss/Gain
___Hip Pain	___Mid Back Pain	___Ankle/Foot Pain	

Mechanism of Injury Information

Please write a brief description of how your injury occurred ____

____

If you injury is NOT due to an automobile collision, please skip to the section titled "Treatment Information"

Were you stopped? (Yes / No) If no, approximate speed: ________ mph

Was the other vehicle stopped? (Yes / No) If no, approximate speed: _________mph

At impact, was your body straight in your seat? (Yes / No) If no, turned to the (Left / Right)

At impact, were you looking straight ahead?(Yes / No) If no, was your head turned to the (Left/Right /Up/Down)

Were you aware that you were about to be hit? (Yes / No)

Were you wearing a seatbelt at the time of the accident? (Yes / No)

Did your (chest / head)hit the steering wheel? (Yes / No) Did an airbag deploy? (Yes / No)

Did your head hit the (Windshield / Side Window)? (Yes / No) Did your shoulder hit the door? (Yes / No)

Did your knees hit the dashboard? (Yes / No) Did the seat break? (Yes / No)

Do you have any (cuts / bruises) from the accident? (Yes / No) If yes, where?____________________________

Was your car equipped with headrests? (Yes / No)

If yes, at what height was the top of the headrest? (Base of head / Mid head / Top of head)

Did you lose consciousness? (Yes / No) If yes, how long ______________________________________

Treatment Information

Did you go to the Emergency Room? (Yes / No) If yes, when? ______________________

Name of the Hospital Emergency Room: ______________________

List any medications that you were given: ______________________

List any instructions that you were given: ______________________

From the following list, circle the treatment(s) that you received at the Emergency Room:

Exam / X-Ray / MRI / CT Scan / Back Brace / Neck Brace / Home Instructions / Other__________

List all the doctors that you have seen as a result of your injuries (other than at the ER):

Date	Doctor	Treatment
1.		
2.		
3.		

Do you have any future appointments with any doctor regarding your injuries? (Yes / No)

If yes, when and with whom? ______________________

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Patient Signature______________________ Date ____________

Guardian Signature (if applicable)______________________ Date____________