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_____

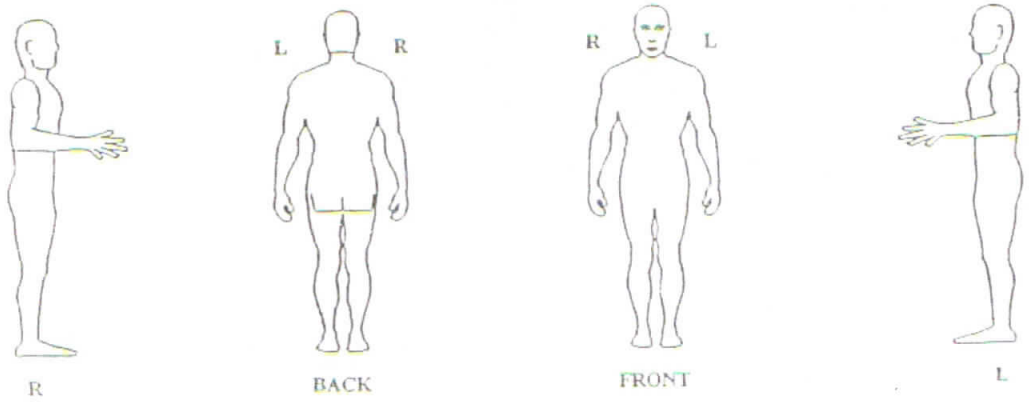
What type of work do you do?_____
Requirements?_____
Have you lost any days of work because of this injury? □ Yes □ No
If yes, date(s)_____

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

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_____