

Desert Shadows Chiropractic and Wellness
Christopher C. Campo, D.C.
4010 E. Bell Rd. #103 Phoenix, AZ 85032
Phone:602-595-0015

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) _____

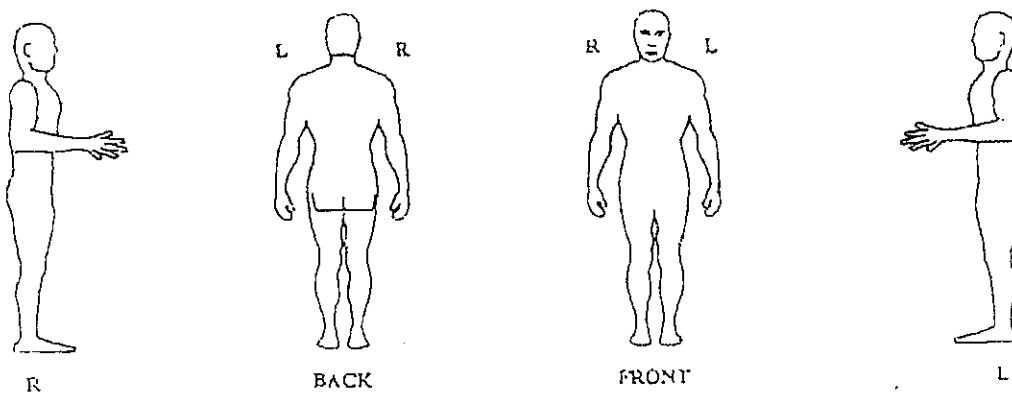
Have you retained an attorney? Yes No Litigation? Yes No Maybe

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)

- | | | | |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Dizziness/Loss of balance | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Rapid heartbeat | <input type="checkbox"/> Blood/Lymph disorders | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Urinary difficulties | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Elbow Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Wrist/Hand Pain |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Memory lapses | <input type="checkbox"/> Hot/Cold Flashes | <input type="checkbox"/> Upper Back Pain |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Ankle/Foot Pain | |

Mechanism of Injury Information

Please write a brief description of how your injury occurred _____

If your 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):

<u>Date</u>	<u>Doctor</u>	<u>Treatment</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

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

If yes, when and with whom? _____

Patient Signature _____ Date _____

Guardian Signature (if applicable) _____ Date _____