SPINALWORKS MEDICAL GROUP
AUTO ACCIDENT INTAKE FORM

About the Collision

Name: _____ Date of Collision _____ Time of Collision _____

Road conditions at the time of collision: ❑ Wet ❑Dry ❑Snow ❑Ice ❑Other: _____

City/State where accident occurred: _____ Intersection: _____

Number of people in your vehicle: _____ Number of vehicles in collision: _____

Did police arrive at the scene? ❑Yes ❑No • Was there a police report? ❑Yes ❑No

Please describe the collision in your own words: _____

_____

The Vehicles Involved

Year, Make, and Model of your vehicle:_____ Damage ($): _____

Were you the: ❑Driver ❑Front Passenger ❑Rear - Left ❑Rear - Middle ❑Rear - Right

Were you expecting the collision? ❑Yes ❑No • How fast were you going?_____ mph

Was your foot on the brake when you were hit? ❑Yes ❑No •Did it get jolted off the brake? ❑Yes ❑No

Did you vehicle spin or roll-over? ❑Spin ❑Roll-over ❑N/A •Did your airbags deploy? ❑Yes ❑No

Were you wearing a seatbelt? ❑Yes ❑No • Did your seatbelt have a shoulder strap? ❑Yes ❑No

Were you looking straight ahead at the time of the collision? ❑Yes ❑No

Year, Make, and Model of the other vehicle: _____ Damage ($): _____

How fast was the other vehicle traveling? _____mph ❑It was stopped

Your Injuries

Did you go to the hospital? ❑Yes ❑No Which hospital? _____Dates _____to _____

Did the hospital do any imaging? ❑No ❑X-ray ❑MRI ❑CT ❑Other: _____

Were you given any medication or supplies(brace, collar, splint)? ❑No ❑Yes(explain): _____

Was any other doctor consulted after the accident? ❑Yes ❑No If yes, please explain below.

Dr.:_____ Specialty: _____ Date first seen: _____

Dr.:_____ Specialty: _____ Date first seen: _____

Did you sustain any cuts/bruises? ❑Yes ❑No If so, where?_____

Did any parts of your body hit the inside of the vehicle? ❑No If yes, explain:_____

_____

Immediately following the collision, did you experience any of the following? ❑Confused ❑Disoriented

❑Light-headed ❑Dizzy ❑Nauseated ❑Blurred vision ❑Ringing in ears ❑Loss of balance

Do you still have any of these symptoms? Explain:_____

Please check any symptoms that you have had since the collision

- ❑ Neck pain
- ❑ Upper back pain
- ❑ Mid back pain
- ❑ Lower back pain
- ❑ Shoulder pain
- ❑ Arm/leg pain
- ❑ Headaches
- ❑ Dizziness
- ❑ Fatigue
- ❑ Loss of sleep
- ❑ Fainting
- ❑ Irritability
- ❑ Loss of balance
- ❑ Buzzing/Ringing in ears
- ❑ Nervousness
- ❑ Loss of memory
- ❑ Vision problems
- ❑ Numbness/tingling
- ❑ Jaw pain
- ❑ Head feels too heavy
- ❑ Urinary problems
- ❑ Digestive problems
- ❑ Chest pain
- ❑ Joint Stiffness
- ❑ Difficulty Swallowing
- ❑ Sciatica
- ❑ Sore muscles
- ❑ Cold hands/feet
- ❑ Depression
- ❑ Loss of smell
- ❑ Anxiety