Weston Medical Health Center
2237 North Commerce Parkway, Ste 2
Weston, FL 33326

Automobile Accident Intake Form

CONFIDENTIAL PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: _________ Age ________ Date: ______________________

Date of Accident: _______________ Time of Accident: _________ am/pm State of Accident:: ______________________

Are you the policy holder for the vehicle? Yes No If No, Name of policy holder: ______________________

Did you report the accident to your insurance? Yes No Name of Insurance Company: ______________________

If yes, please provide your claim number: ____

Were you the only person in the vehicle at the time of the accident? Yes No

If no, please list all persons in the vehicle: ____

____

If no, were you the driver of the policy holder's car or a passenger? ____

Please describe the accident in your own words: ____

____

____

Did the police come to the accident site? Yes No If Yes, Was a police report filed? Yes No

Were you cited for the accident? Yes No

Have you obtained an attorney? Yes No If yes, Name of Attorney: ____

Did you lose consciousness? Yes No

Immediately following the accident, did you feel…? (Circle): Dizzy Dazed Disoriented Nervous Nauseas

Were you able to walk unaided? Yes No

Please list all areas in which you immediately felt pain following the accident: ______________________________

Please list all areas in which you felt pain the FOLLOWING days after the accident: ______________________________

Did you go to the hospital/ER immediately following the accident? Yes No

If yes, how did you get to the Hospital/ER?: ____

Name of Hospital/ER: ____

Name of Doctor who treated you: ____

Did you have X-Rays? Yes No If yes, which areas were X-Rayed? ______________________________

If no, did you seek treatment anywhere for you injuries prior today? Yes No

If yes, Name of Doctor who treated you: ____

Are your symptoms: (Circle) Constant Intermittent

Compared to onset, are your symptoms better, worse, or the same? ______________________________

Do your symptoms prevent you from sleeping? Yes No

Do your symptoms prevent you from working? Yes No If Yes, how long? From Date: ___________ To Date: __________

What improves your symptoms? (Positions, activities, heat/ice, medications) ______________________________

____

What irritates your symptoms? (Positions, activities, heat/ice, medications) ______________________________

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Automobile Accident Intake Form Cont.

CONFIDENTIAL PATIENT INFORAMTION

The Following Pertains to Your Movement at the time of Impact:

Please indicate the position of your head at the time of impact (Circle):.

Tilted Down Tilted Up Turned Left Turned Right

Was your head jolted? Yes No If yes, in which direction? (Circle):

Backward then Forward Forward then Backward To the Left To the Right Left then Right Right then Left

Speed of your vehicle (Circle):

Stopped Parked Slowing Accelerating Moving at approximately_______ MPH

If stopped or slowing, reason (Circle):

Traffic signal Stop sign Pedestrian Parking Traffic

At the time of impact, were you aware that the accident was impending? Yes No

At the time of impact, were both hands on the steering wheel? Yes No

At the time of impact, were you wearing your seatbelt? Yes No

Was your vehicle equipped with an airbag? Yes No Did it deploy? Yes No

The Following Pertains to You and the Vehicle Your Were In:

Make and Model: ____________________________________ Year: ________________________________

Vehicle Type (Circle):

Car Van Pickup Sports Utility Vehicle Station Wagon Commercial Truck

Vehicle Size (Circle):

Subcompact Compact Mid-size Large Car Pick-up Truck SUV Other:

Please indicate the damage to the vehicle you were in. (Circle):

Minimal Moderate Severe Totaled

Collision Type (Circle):

Front Impact Rear Impact Side Impact

Driver Side:

Front Middle Rear

Passenger Side:

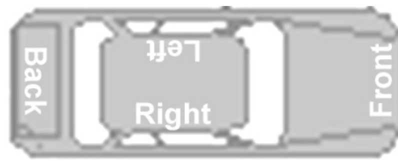
Front Middle Rear

Your Position in the vehicle (Circle): Driver Passenger

If passenger, Where in the row? (Circle):

Front Passenger Rear Passenger Third Row Passenger

Please Indicate Where Your Vehicle Was Struck:



By signing below, I certify that the information I furnish is true and correct. I know that it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature of Patient/Responsible Party____**Today's Date**__________________