DESERT CITIES CHIROPRACTIC

12241 Industrial Blvd. Suite 102
Victorville CA 92395
(760) 952-3300

Personal Injury Intake Form

Name:_____

Date of Accident:_____ **Time of Accident**:_____AM/ PM

What direction were you headed? ☐North ☐South ☐West ☐East **Name of Street**:_____

What direction was the other vehicle headed? ☐North ☐South ☐West ☐East
Name of Street were they on:_____

Were you: ☐Driver ☐Passenger ☐Pedestrian ☐on Bicycle ☐on Motorcycle
If Passenger: ☐Front Seat ☐Back Right ☐Back Left ☐Back Middle

Was your vehicle struck from: ☐Behind ☐the Front ☐the Left ☐the Right

At impact were you: ☐Stopped ☐Moving ☐Walking ☐Standing Still ☐Running ☐Bicycling ☐Riding Motorcycle ☐Crossing Street

At what speed were you moving at impact: ☐Stopped ☐_____MPH

At impact what was the other involved person doing: ☐Stopped ☐Moving ☐Walking ☐Standing Still ☐Running ☐Bicycling ☐Riding Motorcycle ☐Crossing Street

At what speed was the other person moving at impact: ☐Stopped ☐_____MPH

Were you wearing a seat belt? ☐Yes ☐No

At impact was your head:☐Forword ☐turned Right ☐turned Left ☐turned Behind ☐looking Up ☐looking Down

Number of People in vehicle:_____
Did any part of your body strike another structure at impact? ☐Yes ☐No
If Yes, list the area of you body and what structure they struck.
_____

How did you feel immediately after the collision? ☐Stunned ☐Lost Consciousness ☐Felt Intense Pain ☐Felt Discomfort ☐Frightened ☐Felt a popping/ripping sensation ☐Went to the hospital ☐Went home

Check any symptoms you have experienced since being involved in this accident:

☐Headache	☐Neck Pain	☐Stiff Neck	☐Mid Back Pain	☐Low Back Pain	☐Dizziness
☐Fatique	☐Tension	☐Nervous	☐Ringing Ears	☐Numbness/Hands	☐Numbness/Feet
☐Cold Hands	☐Diarrhea	☐Short Breath	☐ Chest Pain	☐ Constipation	☐Loss of Sleep
☐Loss of Smell	☐Loss of Memory	☐Loss of Taste		☐Loss of Appetite	☐Loss of Balance
☐Pins & Needles in Arms/Hands		☐Pins & Needles in Legs/Feet			

☐Other:_____

Do you notice any activities that you cannot do as a result of this accident? ☐Yes ☐No
If Yes, list the activities

_____

Did the airbag deploy? ☐Yes ☐No

Were the Police notified? ☐Yes ☐No

Was A Police Report Made? ☐Yes ☐No

Did you have any physical complaints before this accident? ☐Yes ☐No
If Yes, Explain

_____

Have you ever been in any accidents before? ☐Yes ☐No
If Yes, Explain

_____

Have you lost time from work as a result of this accident? ☐Yes ☐No
If Yes, When was the last day you worked?_____

Patient Signature:_____ Today's Date:_____