**Finesse Chiropractic**

Dr. Marvin Kunikiyo

# Auto Accident New Patient Intake

## PATIENT INFORMATION:

Name (Last, First): ______________________ DOB (MM/DD/YY): ____________

Today's Date (MM/DD/YY) ______________ Age: _____ Sex (M/F): _____

Phone #: ______________ E-mail: ______________________

Street Address: ________________________________

City: __________ State: _______ Zip: _________

Occupation: ____________________ Employer: ________________

Emergency Contact: ________________________ Phone #: ____________

Relationship To Patient: ______________

Marital Status:

__ Married __ Partnership __ Single __ Divorced __ Widowed

Spouse/Partner's Name: ________________________

How did you hear about us? ______________________________________

## MEDICAL INSURANCE INFORMATION:

Insurance Company: ________________________________

Insurance Phone #: __________________ Insurance Fax #: __________________

Member ID: ____________________ Group #: ____________________

Subscriber/Insured: ______________________

Subscriber/Insured DOB (MM/DD/YY): ____________

Relationship to Patient: ___________________

## AUTO INSURANCE INFORMATION:

Insurance Company: ________________________ Claim # ______________

Agent Name: ____________________________ Phone #: ______________

Date of Accident: ______________ Do you have PIP Coverage (Y/N)? __________

Amount ($): __________

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## AUTO ACCIDENT INFORMATION

Date and time of accident: ____________ ____________ ☐a.m. ☐p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐Rear Passenger

Number of other passengers: _______

Would you like to discuss chiropractic care for other passengers of the vehicle? (Y/N): ________

Make and model of the vehicle you were occupying: ______________________________

If a traffic violation was issued, to whom was it issued: ______________________________

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/ they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐Another vehicle ☐ Other

If other, please explain: ______________________________________________________

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: ______________________________________________________

Make and model of the other vehicle(s) involved? ________________________________________

What was the approx. speed of your vehicle? _________

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐Forward

Were you: ☐ Aware or ☐ Surprised by the impact

Approximate Speed of the other vehicle? __________

In your words, please describe the accident:

| |
|---|
| |
| |

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## PRIOR TO INJURY

List any other Injuries, Traumas, Broken Bones and Surgeries you have had in the past, include dates: ______________________________

Are you taking any medications or supplements? Please list ______________________________

______________________________

Allergies: ______________________________

Date of last physical exam: ______________

Date of last chiropractic exam: ______________

**Females:**

Date of last menstrual cycle: ______________

Is there a possibility you could be pregnant? ☐ Yes ☐ No

Any prior pregnancies? ☐ Yes ☐ No

Any associated complications? Please list ______________

## AFTER INJURY

Did the accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? ______________________________

Please describe how you felt immediately after the accident: ______________________________

______________________________

Have you gone to a hospital or seen any other Doctor? ☐Yes ☐ No

When did you go? ☐ Just after accident ☐The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐Private transportation

Name of hospital and/ or attending doctor: ______________________________

Treatment Received: ______________________________

Were X-Rays taken? ☐ Yes ☐ No

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Have you been able to work since this injury? ☐Yes ☐No

Are your work activities restricted as a result of this injury? ☐Yes ☐ No

Indicate the symptoms that are a result of this accident:

| | | | |
|---|---|---|---|
| ☐ Dizziness | ☐ Difficulty Sleeping | ☐ Jaw problems | ☐ Nausea |
| ☐ Memory loss | ☐ Irritability | ☐ Arms/shoulder pain | ☐ Back pain |
| ☐ Headache(s) | ☐ Fatigue | ☐ Lower back pain | ☐ Numbness |
| ☐ Blurred vision | ☐ Tension | ☐ Back stiffness | ☐ Ears buzzing |
| ☐ Neck pain | ☐ Neck stiff | ☐ Chest pain | ☐ Ears ringing |
| ☐ Leg pain | ☐ Numb feet/ toes | ☐ Stomach upset | ☐ Fainting |
| ☐ Loss of Memory | ☐ Pins & Needles in Legs | ☐ Pins & Needles in Arms | ☐ Tingling |
| ☐ Other (describe below) | | | |

Describe:

______________________________________________

Is your condition getting worse? ☐Yes ☐ No ☐ Constant ☐ Comes and goes

Indicate your degree of comfort while performing the following activities:

| | Comfortable | Uncomfortable | Painful |
|---|---|---|---|
| Lying on back.................................... | ☐ | ☐ | ☐ |
| Lying on side.................................... | ☐ | ☐ | ☐ |
| Lying on stomach.......................... | ☐ | ☐ | ☐ |
| Sitting.......................................... | ☐ | ☐ | ☐ |
| Standing...................................... | ☐ | ☐ | ☐ |
| Stretching.................................... | ☐ | ☐ | ☐ |
| Lovemaking.................................. | ☐ | ☐ | ☐ |
| Walking....................................... | ☐ | ☐ | ☐ |
| Running....................................... | ☐ | ☐ | ☐ |
| Sports.......................................... | ☐ | ☐ | ☐ |

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| | | | |
|---|---|---|---|
| Working.......................................... | ☐ | ☐ | ☐ |
| Lifting............................................. | ☐ | ☐ | ☐ |
| Bending.......................................... | ☐ | ☐ | ☐ |
| Kneeling....................................... | ☐ | ☐ | ☐ |
| Pulling.......................................... | ☐ | ☐ | ☐ |
| Reaching...................................... | ☐ | ☐ | ☐ |

**RECOVERY:**

How many hours are in your normal workday? ____________

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform

☐ Standing ☐ Driving ☐ Operating equipment

☐ Sitting ☐ Crawling ☐ Typing

☐ Lifting ☐ Bending ☐ Stooping

☐Other ______________________________________________

What positions can you work in with minimum physical effort and for how long? ________________

______________________________________________________________________________

Prior to the injury were you capable of working on an equal basis with others your age?

☐Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐Yes ☐ No ☐

While in recovery, is there any light duty work you could request? ☐Yes ☐ No ☐

Recreational activities: ______________________________________________

**Have you retained an attorney**: ☐ Yes ☐ No

If yes, whom? ______________________________________

His/ Her phone #:________________________

Address: ________________________________________________________

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- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- **I understand and agree that all services rendered to me are my financial responsibility and any health or accident insurance policies which I hold are based on a contract between the carrier and myself. I also understand that I am financially responsible for all non-covered services.**
- I authorize the staff to perform any necessary services needed during diagnosis and treatment in accordance with this state's statutes. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ______________________________ Date: ______________

☐Patient ☐Parent or Guardian ☐Spouse