

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
Fatigue 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 been treated by any other doctors for this accident? Yes No

If Yes, Please list Doctors:

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: _____