synergyhealth

# MOTOR VEHICLE ACCIDENT INTAKE

Name: _____ Date: _____

- Is your chief complaint related to any of the following:

  Y = Yes N = No *Circle All That Apply*

  Motor Vehicle Accident **Y N**

  Workers Comp Injury **Y N**

  Date of Injury: _____

- Attorney or Adjuster

  Name: _____

  Phone: _____

  Claim #: _____

  Insurance Company: _____

- Road Conditions:

  ☐ Wet ☐ Dry ☐ Snow/Sleet

- Did you go to the hospital? ☐ Yes ☐ No

  If yes, where?: _____

- Did the police come?

  ☐ Yes ☐ No

- Were you taken by an ambulance?

  ☐ Yes ☐ No

- Has your injury forced you to miss work?

  ☐ Yes ☐ No

  If yes, how much?: _____

- Any medication given?

  ☐ Yes ☐ No

- Were X-rays taken?

  ☐ Yes ☐ No

- Please describe the accident in detail: _____

  _____

- Were you wearing a seatbelt?

  ☐ Yes ☐ No

- Were you aware of the impending collision?

  ☐ Yes ☐ No

- Did you strike anything inside the car?

  ☐ Yes ☐ No

- Did you lose consciousness?

  ☐ Yes ☐ No If yes, how long? _____

- Were you the driver?

  ☐ Yes ☐ No If not, where were you? _____

- Please list all symptoms you have experienced since the accident: _____

  _____

  _____

- Describe how you felt immediately following the accident:

  _____

  _____

  _____

- Please describe the accident in detail: _____

  _____

- Have you ever been in another motor vehicle accident? ☐ Yes ☐ No

  If yes, when?: _____

- Were you injured?

  ☐ Yes ☐ No If yes, describe the injury: _____

  _____

Signature:_____ Date:_____