New Patient Intake – Motor Vehicle Accident

Please fill out the form in as much detail as possible.

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Patient information

Name _____ Date _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Phone: Home _____ Mobile _____ Work _____

Age _____ Date of birth _____ Social Security # _____ Sex: ☐ M ☐ F

Occupation _____ Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Height _____ Weight _____ E-mail address _____

Emergency contact _____ Relationship _____ Phone _____

Your problem

Primary problem _____

Date of injury/onset _____

How did it happen? _____

What makes it worse? _____

What makes it better? _____

Rate your problem (1 = no pain, 10 = unbearable): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is the problem getting worst? ☐ No ☐ Yes If yes, explain: _____

Describe how the pain feels (sharp, dull, achy, shock-like, burning, etc.): _____

Does the problem radiate into the arms/legs? ☐ No ☐ Yes Where: _____

At what time of day is the problem worst? ☐ Constant ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

Have you ever had a similar problem before? ☐ No ☐ Yes When: _____

Are you taking any medication for this problem? ☐ No ☐ Yes List: _____

Health history

Please check No or Yes for each of the following:

Condition	No	Yes	Condition	No	Yes	Condition	No	Yes
Recent infection	☐	☐	Headaches	☐	☐	Cancer/tumor _____	☐	☐
Recent fever	☐	☐	Jaw pain ☐ Left ☐ Right	☐	☐	Recent frequent urination	☐	☐
HIV / AIDS	☐	☐	Neck pain	☐	☐	Recent urinary retention	☐	☐
Diabetes	☐	☐	Upper back pain	☐	☐	Birth control pills	☐	☐
High blood pressure	☐	☐	Lower back pain	☐	☐	Pregnancy _____	☐	☐
Epilepsy / seizures	☐	☐	Shoulder pain ☐ Left ☐ Right	☐	☐	Numbness in the groin/buttocks	☐	☐
Dizziness / fainting	☐	☐	Elbow pain ☐ Left ☐ Right	☐	☐	Prostate problems	☐	☐
Visual disturbance	☐	☐	Wrist/hand pain ☐ Left ☐ Right	☐	☐	Stroke _____	☐	☐
Osteoporosis	☐	☐	Hip pain ☐ Left ☐ Right	☐	☐	Alcohol use _____	☐	☐
Corticosteroid use	☐	☐	Knee pain ☐ Left ☐ Right	☐	☐	Tobacco use _____	☐	☐
Arthritis	☐	☐	Ankle pain ☐ Left ☐ Right	☐	☐	Surgeries _____	☐	☐
Aortic aneurysm	☐	☐	Foot pain ☐ Left ☐ Right	☐	☐	Medications _____	☐	☐

Family history: ☐ Arthritis ☐ High blood pressure ☐ Cancer ☐ Diabetes ☐ Heart problems

Certification

I certify that the above information is true and accurate. I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due and payable.

Patient's signature _____ Date _____

Assignment and Lien Authorization

For (patient's name): _____

Provider: David D. Van, DC, 6355 Topanga Canyon Blvd., #504, Woodland Hills, CA 91367. Phone: (818) 884-2576. Fax: (818) 884-8054.

To (attorney at law): _____

Attorney address, line 1: _____

Attorney address, line 2: _____

I do hereby authorize the Provider named above and or authorized representatives to furnish you, my attorney or any attorney or attorneys who subsequently are either Associates with said named attorney, or substituted in his/her place, with a full report of their examination, diagnosis, treatment, prognosis, and itemized statement of charges in regard to the accident which I was involved. Furthermore, I hold the Provider, free and harmless from any liability in such transfer of information.

I hereby authorize direct payment to the Provider such sums due and owing to them for medical service rendered me both by reason of this accident or by reason of any other bills that are due their office, and to withhold such sums from any settlement, judgment or verdict as may be necessary to protect said Provider. I further give a lien to said Provider on any and all funds received by me or on my behalf in connection with any settlements, judgments or verdicts regarding this case. I agree never in rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in. this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

In the event legal action shall be taken in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment or settlement rendered. I fully understand that I am directly and fully responsible to Provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for said Provider’s additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

A PHOTOGRAPHIC REPRODUCTION OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL

Patient's signature: _____ Date: _____

The undersigned being the attorney of record on his/her own behalf and on behalf of any other attorney or attorneys who are Associates with the undersigned or who are substituted in his/her stead for the above patient, does hereby acknowledge that he/she is obligated to all terms stated above, and agrees to withhold such sums from any settlements, judgments, or verdicts as is necessary to adequately protect said Provider.

Attorney's signature: _____ Date: _____

Motor Vehicle Crash Form (Page 1)

Patient name: _____ Date: _____

Date of injury: _____ Time of injury: _____ ☐ AM ☐ PM

City where crash occurred: _____ Was the street wet or dry? ☐ Wet ☐ Dry

Street (location) where crash occurred: _____

What is the estimated damage to your vehicle? $ _____

Who made damage estimates on your vehicle? _____

Who owns the vehicle you were involved in? _____

Did the police come to the accident scene? ☐ Yes ☐ No

Did the police make a written report? ☐ Yes ☐ No

Were any photographs taken of your vehicle? ☐ Yes ☐ No If yes, who took them? _____

Describe how the crash happened

Collision description – type

Check all that apply. Indicate which type of car crash you were involved in:

☐ Single-car crash ☐ Two-vehicle crash ☐ Three or more vehicles ☐ Rear-end crash ☐ Side crash

☐ Rollover ☐ Head-on crash ☐ Hit guard rail, tree, or object ☐ Ran off the road ☐ Other

Other (describe): _____

Indicate your seating position

☐ Driver ☐ Front passenger ☐ Left rear passenger ☐ Right rear passenger

Describe the vehicle you were in

Model, make, and year: _____

☐ Small-sized car ☐ Mid-sized car ☐ Large-sized car ☐ Pick-up truck ☐ Van ☐ Sport utility vehicle

☐ 2 door vehicle ☐ 4 door vehicle ☐ Large truck, bus, or semi-truck ☐ Sedan ☐ Hatchback

☐ Station wagon ☐ Other

Other (describe): _____

Describe the other vehicle (if not certain, leave blank)

Model, make, and year: _____ ☐ Unknown

☐ Small passenger car ☐ Mid-sized passenger car ☐ Van ☐ Pick-up truck/sports utility

☐ Large-sized passenger car ☐ Large truck, bus, or semi-truck

Motor Vehicle Crash Form (Page 2)

At the time of impact your vehicle was:

☐ Slowing down ☐ Gaining speed ☐ Stopped ☐ Moving at steady speed

At the time of impact the other vehicle was:

☐ Slowing down ☐ Gaining speed ☐ Unknown speed ☐ Stopped ☐ Moving at steady speed ☐ Other

During and after the crash, your vehicle:

☐ Kept going straight, not hitting anything ☐ Spun around, not hitting anything

☐ Kept going straight, hitting car in front ☐ Spun around, hitting another car ☐ Was hit by another vehicle

☐ Spun around, hitting object other than car

Indicate if your body hit something or was hit by any of the following

For each body region that made contact, write what it hit. Objects: windshield, side window, side door, dashboard, knee bolster/glove compartment, seatbelt, frame of car near windows, roof of vehicle, another occupant/animal, other.

Body region	Object you had contact with
Head	
Face	
Shoulder	
Arm/hand	
Front chest wall	
Side chest wall	
Hip/abdomen	
Knee	
Leg	
Foot	

Check if any of the following vehicle parts broke, bent, or were damaged in your car:

☐ Windshield ☐ Seat frame ☐ Knee bolster ☐ Steering wheel ☐ Side-rear window ☐ Dash ☐ Mirror

☐ Other

Other (describe): _____

All types of collisions – indicate those relevant to your case

Yes	No	Question
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floorboard of your car dent inward during the crash?
☐	☐	Did the side door touch your body during the crash?
☐	☐	Did your body slide under the seatbelt?
☐	☐	Was the door(s) of your vehicle damaged to point where you could not open the door?
☐	☐	Did an airbag deploy in your vehicle during the crash?
☐	☐	Were you intoxicated (alcohol) at the time of crash?

If an airbag deployed, which: ☐ Side air bag ☐ Front air bag

Motor Vehicle Crash Form (Page 3)

Seatbelt usage and steering wheel hand placement

Yes	No	Question
☐	☐	Were you wearing a seatbelt?
☐	☐	Indicate if you had any portion of your seatbelt positioned behind your back or shoulder.
☐	☐	Were you holding onto the steering wheel (driver only) at the time of impact?

If wearing a seatbelt, does it have a: ☐ Lap and shoulder strap ☐ Lap belt only

If holding the wheel, indicate where each hand was positioned (use a clock face as your reference point):

Left hand: ☐ Not on wheel ☐ On wheel ☐ Hand elsewhere at o'clock: _____

Right hand: ☐ Not on wheel ☐ On wheel ☐ Hand elsewhere at o'clock: _____

Rear-end collisions only (answer only if you were hit from the rear)

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint ☐ Fixed, non-moveable head restraint ☐ No headrests in my vehicle

☐ Bench seat without head restraint

How was your head restraint positioned at the time of crash (if present)?

☐ At the top of the back of your head ☐ Midway height of the back of your head

☐ Lower height of the back of your head ☐ Located at the level of your neck ☐ Level of your shoulder blades

Bruising after the crash

Yes	No	Question
☐	☐	Did your body have any bruising (areas that were visibly black and blue) after the crash?

If yes, indicate where: _____

Awareness and body position descriptions (check all that apply)

☐ You were unaware of the impending collision. You did not see or hear brakes prior to the impact.

☐ You were aware of the impending crash and relaxed before the collision.

☐ You were aware of the impending crash and braced yourself.

☐ Your body, torso, and head were facing straight ahead.

☐ You had your head and/or torso turned at the time of collision

☐ You were leaning forward at the time of impact resulting in a gap between your body and the seatback

☐ Your torso and body was positioned normally against the seatback with no gaps due to leaning/twisting

If turned: ☐ Turned to left ☐ Turned to right

Describe how far you were turned/twisted and why:

Automobile Insurance Information

Do you or someone else have insurance coverage for the vehicle you were in? ☐ I have

☐ Someone else has coverage

Name of person policy is under: _____

How is this person related to you? ☐ Self ☐ Parent ☐ Friend ☐ Other

Automobile insurance carrier: _____

Phone number of automobile insurance carrier: _____

Claim adjuster's name: _____

Claim adjuster's telephone number: _____

Claim number: _____

Do you have an insurance deductible? ☐ No ☐ Yes Deductible is: $ _____

Do you know your policy limits for medical bills? ☐ No ☐ Yes Limit is: $ _____

Have you reported this injury to your insurance carrier? ☐ No ☐ Yes

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office.

It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible.

Attorney

Do you have an attorney representing you? ☐ No ☐ Yes

Attorney name: _____

Address: _____

Telephone: _____

Signature _____ Date _____

Print name _____

If you need this form in another format or help completing it, call (818) 518-6204.