SYLVAN CHIROPRACTIC CLINIC AND WELLNESS CENTER, LLC
5440 SW WESTGATE DR., SUITE 100 ♦ PORTLAND, OR. 97221 ♦ 503.297.4447 ♦ FAX: 503.296.8414

MOTOR VEHICLE ACCIDENT PATIENT FORM

Please answer all the questions completely. All information provided is strictly confidential.
If you do not understand a question or are unsure of the information, please ask for assistance.

Patient Name: _____ Date: _____
In the accident, you were the: □ DRIVER □ PASSENGER □ PEDESTRIAN/CYCLIST □ OTHER
Date of Injury: _____ Time of Injury: _____ □ AM □ PM
City where crash occurred: _____Was the street wet or dry? □Wet □Dry
Street (location) where accident 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 If yes, report number if known: _____
Were photographs taken of your vehicle? □ Yes □ No If yes, who took them: _____
Do you have automobile medical insurance coverage? □ Yes □ No Company Name: _____
Address: _____City:_____
State: _____Zip:_____Phone:_____
Have you reported this injury to your car insurance company? □ Yes □ No
Adjuster's Name: _____ Phone: _____
Policy #:_____Claim #:_____
Is an attorney representing you? □ Yes □ No Name: _____
Address: _____City:_____
State: _____ Zip: _____ Phone:_____
Have you been in a motor vehicle accident before? □ Yes □ No If yes, when? _____

DESCRIBE HOW THE CRASH HAPPENED:

_____
_____
_____
_____
_____
_____
_____

COLLISION DESCRIPTION:

Check all that apply to you. Indicate which type of automobile accident 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 (Describe):_____

DESCRIBE THE VEHICLE YOU WERE IN:

Make: _____ Model:_____ 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, semi-truck

☐ Sedan ☐ Hatchback ☐ Station wagon

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DESCRIBE THE OTHER VEHICLE:

Make: _____ Model:_____ Year:_____ ☐ unknown

☐ Small car ☐ Mid-sized car ☐ Van

☐ Pick-up truck/sports utility ☐ Full-sizes car ☐ Large truck, bus, semi-truck

AT THE TIME OF IMPACT YOUR VEHICLE WAS:

☐ Slowing down ☐ Gaining speed ☐ Stopped, brake engaged ☐ Stopped, no brake ☐ 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: (Please draw lines from the body regions on the left side and match to the right side.)

BODY REGION	OBJECT YOU HAD CONTACT WITH
Head	Windshield
Face	Side Window
Shoulder	Side Door
Arm/Hand	Dashboard
Front chest wall	Knee bolster/Glove compartment
Side chest wall	Seatbelt
Hip/Abdomen	Frame of car near windows
Knee	Roof of window
Leg	Another occupant/Animal
Foot	Roof
	Steering wheel/Column

CHECK IF ANY OF THE FOLLOWING VEHICLE PARTS BROKE, BENT, OR WERE DAMAGED IN YOUR CAR:

☐ Windshield	☐ Seat frame	☐ Knee bolster	☐ Steering wheel	
☐ Side or rear window	☐ Brake pedal	☐ Dash	☐ Mirror	☐ Other

ALL TYPES OF COLLISIONS (Indicate those relevant to your case):

YES NO 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?

☐ ☐ Was the door(s) of your vehicle damaged to a point where you could not open the door?

☐ ☐ Did your body slide under the seatbelt?

☐ ☐ Did an airbag deploy in your vehicle during the crash?

☐ ☐ Were you intoxicated (alcohol) at the time of the crash?

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SEATBELT USAGE AND STEERING WHEEL HAND PLACEMENT:

YES NO

☐ ☐ Were you wearing a seatbelt?

If yes, does your seatbelt have a: ☐ Lap and shoulder strap, ☐ Lap belt only

☐ ☐ 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 yes, indicate where each hand was positioned (Use time clock face as your reference point)

Left hand: ☐ Not on wheel, ☐ Yes, hand at ___o'clock, ☐ Hand elsewhere

Right hand: ☐ Not on wheel, ☐ Yes, hand at ___o'clock, ☐ Hand elsewhere

REAR-END COLLISIONS ONLY **(Answer this section only if you were hit from the rear):**

Describe your vehicle's head restraint system:

☐ Movable/adjustable head restraint ☐ Fixed, non-movable head restraint

☐ No headrests in my vehicle ☐ Bench seat in your vehicle without head restraint

Please indicate how your head restraint was 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 the neck

☐ Level of your shoulder blade

Estimated distance between back of head and front of headrest: _____

BRUISING AFTER THE CRASH:

YES NO

☐ ☐ 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 areas that apply to you):**

☐ 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: ☐ Turned to the left, ☐ Turned to the right

Describe how far you were turned/twisted and why?

☐ 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.

EMERGENCY ROOM AND DISABILITY DATES:

YES NO

☐ ☐ Did you go to the emergency room afterward? If yes, date and time:_____
Name of the emergency room? _____City: _____

☐ ☐ Did you go to the emergency room in the ambulance?
If yes, name of ambulance company: _____

☐ ☐ Did you or another person drive you to the emergency room?
Name of person: _____

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YES NO

☐ ☐ Were you hospitalized after being seen in Emergency Room?
If yes, how many days: _____

☐ ☐ Did the emergency room doctor take X-rays? Check what regions x-rays were taken:

☐ Skull/Face x-rays ☐ Ribs/Chest

☐ Neck or Middle back x-rays ☐ Collar bone

☐ Low back or Hip/Pelvis x-rays ☐ Shoulder, Arm or Hand

☐ Leg or Foot ☐ Other

☐ ☐ Did the hospital or clinic take MRI or CT of your body? If yes, indicate where taken:

☐ Skull ☐ Neck ☐ Low back or hip/pelvis ☐ other

☐ ☐ Did you have any broken bones/fractures? If yes, where: _____

☐ ☐ Did you have a cast put on for any sprain or fracture? If yes, type/location: _____

☐ ☐ Did you have any dislocations? If yes, where: _____

☐ ☐ Did you have any cuts or lacerations? If yes, where: _____

☐ ☐ Did you have any skin abrasions? If yes, where: _____

☐ ☐ Did you require any stitching for cuts? If yes, where: _____

☐ ☐ Did you have any visible bruises or lumps? If yes, where: _____

☐ ☐ Did you have any visible bruises along the shoulder or lap portions of your seatbelt?

☐ ☐ Did the Emergency Room doctor give you any pain medications?

☐ ☐ Did the Emergency Room doctor give you any muscle relaxants?

☐ ☐ Did the Emergency Room doctor give you any other medications/prescriptions?
If yes, what were the medications and dosages? _____

☐ ☐ Were you told you had a herniated or bulging disc in your neck or back?
If yes, where: _____

☐ ☐ Were you given a neck collar or back brace to wear?

☐ ☐ Did you require any surgery after the accident?
If yes, describe type and date: _____

☐ ☐ Were you hospitalized overnight? If yes, indicate dates hospitalized: _____

HOW SOON DID YOU FIRST NOTICE ANY PAIN OR SORENESS AFTER YOU YOUR INJURY?:

☐ Less than 24 hours after injury ☐ Began 1-7 days after injury ☐ Began ___ days after injury

IF YOU DID NOT SEE A DOCTOR FOR THE FIRST TIME UNTIL AFTER TWO WEEKS FROM THE INJURY DATE, INDICATE WHY: (Check all that apply only if you had delay in seeing a doctor)

☐ No pain was noticed

☐ No appointment schedule available

☐ Thought pain would go away

☐ No transportation

☐ Work/home schedule conflicts

☐ Other: _____

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DISABILITY: HAVE YOU BEEN ABLE TO WORK SINCE INJURY?

☐ YES ☐ NO Have you lost days off work? If yes, you were off work: ☐ Partially ☐ Completely
Please list all dates off work: From: _____to_____.
·If you had neck and/or back pain so severe that you were unable to get out of bed, how many hours after the accident did you develop this disabling level of pain? _____

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom does not apply to you.

SYMPTOM LIST	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS CURRENTLY	HAD SIMILAR SYMPTOMS WITHIN ONE YEAR BEFORE THIS INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Irritability				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Anxiety				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching				
Neck stiffness				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Rib cage pain				
Low back pain/soreness/aching				
Hip pain				
Leg pain				
Leg numbness/tingling				
Pain shoots down back of leg				
Knee pain				
Ankle/foot pain				

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PROVIDERS SEEN SINCE INJURY OR WHEN CONDITION BEGAN:

Start with the first doctor you went to after your injury or condition began and list all providers (all types of doctors or therapists) up to your last provider seen and check all that apply for each. Be certain to list these in sequence from first to last.

(1) Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____Date:_____

Indicate what was done:

☐ Exam-consultation ☐ Rehabilitation ☐ Exercises
☐ IME exam or consult only ☐ Ultrasound ☐ Acupuncture
☐ X-ray of neck ☐ Spinal adjustments ☐ Injection (s)
☐ X-ray of chest/mid back ☐ Muscle massage/myotherapy ☐ Wrist brace-splint
☐ X-ray of low back ☐ Muscle stimulation ☐ Neck collar (brace)
☐ Other X-rays ☐ Physical therapy ☐ Low back brace
☐ MRI/CT scan ☐ Anti-inflammatory medications ☐ Heat packs
☐ EMG/ Nerve conduction study ☐ Pain medications ☐ Ice packs
☐ Other tests ☐ Muscle relaxants ☐ Other
Indicate if treatment with this provider: ☐ Helped ☐ Did not help ☐ Other

(2) Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____Date:_____

Indicate what was done:

☐ Exam-consultation ☐ Rehabilitation ☐ Exercises
☐ IME exam or consult only ☐ Ultrasound ☐ Acupuncture
☐ X-ray of neck ☐ Spinal adjustments ☐ Injection (s)
☐ X-ray of chest/mid back ☐ Muscle massage/myotherapy ☐ Wrist brace-splint
☐ X-ray of low back ☐ Muscle stimulation ☐ Neck collar (brace)
☐ Other X-rays ☐ Physical therapy ☐ Low back brace
☐ MRI/CT scan ☐ Anti-inflammatory medications ☐ Heat packs
☐ EMG/ Nerve conduction study ☐ Pain medications ☐ Ice packs
☐ Other tests ☐ Muscle relaxants ☐ Other
Indicate if treatment with this provider: ☐ Helped ☐ Did not help ☐ Other

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(3) Name Emergency Room, hospital/doctor/therapist/center: _____

Address: _____Date:_____

Indicate what was done:

☐ Exam-consultation ☐ Rehabilitation ☐ Exercises
☐ IME exam or consult only ☐ Ultrasound ☐ Acupuncture
☐ X-ray of neck ☐ Spinal adjustments ☐ Injection (s)
☐ X-ray of chest/mid back ☐ Muscle massage/myotherapy ☐ Wrist brace-splint
☐ X-ray of low back ☐ Muscle stimulation ☐ Neck collar (brace)
☐ Other X-rays ☐ Physical therapy ☐ Low back brace
☐ MRI/CT scan ☐ Anti-inflammatory medications ☐ Heat packs
☐ EMG/ Nerve conduction study ☐ Pain medications ☐ Ice packs
☐ Other tests ☐ Muscle relaxants ☐ Other
Indicate if treatment with this provider: ☐ Helped ☐ Did not help ☐ Other

Thank you for completing this questionnaire and intake form regarding your recent accident and injury. The information provided will help us create the most effective treatment for your rapid improvement.

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ACKNOWLEDGEMENT AND UNDERSTANDING

I hereby acknowledge that I am receiving (or am about to receive) healthcare services at the Sylvan Chiropractic Clinic and Wellness Center, LLC, and that I have been advised that the doctor(s) providing the services is (are) willing to wait for payment for these services, provided that there continues to be reasonable certainty that payment will be made either by insurance proceeds or out of the settlement of liability.

I understand that if it is determined either:

1. That there is no insurance company obligated to pay for these services, or if the insurance company involved refuses to acknowledge an assignment to the doctor(s) or make other provisions for the protection of the interest of the doctor(s); or

2. If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor(s), or I have not engaged in the services of an attorney, then payment for services rendered by the doctor(s) at the Sylvan Chiropractic Clinic and Wellness Center, LLC, will be made by me on a current basis and my bill will be paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever comes first.

In the event that a settlement pays less than 100% of the invoiced amount from the Sylvan Chiropractic Clinic and Wellness Center, LLC due to a diminished fee being offered by my attorney at any point, I am responsible for the balance owed to the Sylvan Chiropractic Clinic and Wellness Center, LLC, and arrangements for payment will be made accordingly in no less than thirty days.

Dated the _____ day of _____, 20_____.

Patient's Name _____

Patient's Signature _____