ACTIVE FAMILY CHIROPRACTIC

AUTO INTAKE FORM

(Please circle one)

Position in the vehicle: Driver
Front passenger
Left rear passenger
Right rear passenger
Middle rear passenger

(Please circle one)

Seat Restraints: Unrestrained
Lap belt
Shoulder Harness
Shoulder harness + lap belt

(Please circle one)

Type of vehicle you were traveling in: Bike Compact car Large truck Mini van
Midsize car Motorcycle Pickup truck

(Please circle one for each category)

Your vehicle was: Struck **OR** Struck another **Where:** Back end Front end
Right back end Left back end
Right front end Left front end
Driver's side

(Please circle one)

At the time of the impact, your vehicle was: Stopped at intersection
Stopped in traffic
Slowing down
Accelerating
Making a Left turn
Making a Right turn
Traveling in traffic

Was there a secondary impact? YES / NO
(Was your car pushed into another?)

(Please circle one)

Estimated speed of impact: 1-5, 5-10, 10-20, 20-30, 30-40, 40-50, 50-60

(Please circle one for each category)

Road Conditions: Dry
Wet
Snow covered

Visibility: Excellent
Good
Fair
Poor

(Please Circle one)

Was vehicle equipped w/ airbag system? YES / NO **Which airbag deployed?** Front
Side
Front + Side

Was seat back failure reported? YES / NO
(Did your seat collapse backwards?)

Were you aware of impending collision? YES / NO

(Please circle one)

What was your physical state at time of the accident? Relaxed
Tensed for impact
Clenching the steering wheel

What was the position of your head at impact? Facing forward
Rotated left
Rotated right
Facing up
Facing down

What was the position of your head rest? Even w/the head
Even with bottom of head
Absent

Was bodily impact reported? YES / NO

Was loss of consciousness reported? YES / NO

(Please circle one for each category)

Where did you go after the accident?	**When?**	**How?**
Home	Immediately following	Ambulance
ER	Several hours after	Self transport
Drs. Office	One day after	Family member
Work	Several days after	Friend
	Several weeks after	Air transport

(Please circle one)

Type of treatment provided? Medicine for pain
Medicine for spasm
X-rays
MRI
CT
Ice
Ultra sound
Stitches
Emergency life saving procedures

Your condition since accident? No Change
Slight improvement
Significant improvement
Become worse
Become much worse

Your condition interferes with: Sleep
Work
Performing activities of daily living

List all Doctors seen for this accident

1. Name _____ **Still Under Care?** Y / N
   Date_____
   Reason _____

2. Name_____ **Still Under Care?** Y / N
   Date_____
   Reason_____

3. Name_____ **Still Under Care?** Y / N
   Date_____
   Reason_____