HEALING WAY CHIROPRACTIC
13110 SE Sunnyside Rd.
Suite B
Clackamas, OR 97015
o: 503-698-5866
f: 503-698-5787
Dr. Zachary Taylor, DC

NEW PATIENT INTAKE FORM - MOTOR VEHICLE ACCIDENT

Today's Date: _____/_____/_____ Name: _____

Address: _____

Age: _____ Date of Birth: _____/_____/_____ Gender: _____ Height: _____'_____" Weight: _____

Primary Phone: _____ Is this a cell phone? YES NO Work Phone: _____

Occupation/Employer: _____ Email : _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Insurance Company: _____ Member ID / Claim Number: _____

Primary Physician: _____ Location:_____ Phone: _____

How did you find this office: _____

HWC

When was the car collision?

_____/_____/_____

Where did the collision take place?

☐ Parking lot ☐ City street ☐ Highway ☐ Other: _____

What was the collision with?

☐ Another vehicle (*what kind*): _____

☐ Stationary object (*what kind*): _____

What was your vehicle's situation:

☐ Stopped (*where and doing what*): _____

☐ Moving (*how fast*): _____mph ☐ Accelerating ☐ Maintaining speed

☐ Decelerating (*why*): _____

☐ Turning ☐ Driving straight ☐ Driving in reverse ☐ Lost control

☐ I was a motorcyclist ☐ I was a pedestrian ☐ I was a bicyclist

What was the other object's/vehicle's situation:

☐ Stopped (*where and doing what*): _____

☐ Moving (*how fast*): _____mph ☐ Accelerating ☐ Maintaining speed ☐ Decelerating

☐ Turning ☐ Driving straight ☐ Driving in reverse ☐ Lost control

☐ More than one vehicle (*describe*): _____

☐ Stationary object: _____ ☐ Other: _____

What part of your car was hit?

☐ Front bumper ☐ Front-Driver side ☐ Front-Passenger side ☐ Driver side door(s) ☐ Passenger side door(s)

☐ Rear bumper ☐ Rear-Driver side ☐ Rear-Passenger side ☐ I was a pedestrian/cyclist, so this question is not applicable

☐ Other: _____

Doctor's initials in lieu of signature _____

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What part of the other car was hit?

☐ Front bumper ☐ Front-Driver side ☐ Front-Passenger side ☐ Driver side door(s) ☐ Passenger side door(s)

☐ Rear bumper ☐ Rear-Driver side ☐ Rear-Passenger side

☐ Other: _____

Where in your car were you sitting?

☐ Driver ☐ Front seat passenger ☐ Rear seat, driver's side ☐ Rear seat, passenger's side ☐ Other: _____

Were you wearing a seatbelt? ☐ No ☐ Yes

Did the airbag deploy? ☐ No ☐ Yes

Did you hit your head? ☐ No ☐ Yes

What direction were you looking toward when the collision occurred?

☐ Forward ☐ Left ☐ Right ☐ Up ☐ Down ☐ I don't recall

Did you lose time, blackout, don't remember what happened, or in any way lose consciousness?

☐ No ☐ A few seconds ☐ <1 minute ☐ <5 minutes ☐ >5 minutes ☐ I don't know

In the first few hours after the collision, did you experience any of the following?

☐ Difficulty thinking ☐ Difficulty remembering information you normally know easily

☐ Difficulty calculating simple things you could normally do easily ☐ Difficulty speaking a complete sentence

☐ Mood swings without cause ☐ Other cognitive problems: _____

Are there any details of this event that you do not personally remember, but were told about after the fact?

☐ No ☐ Yes: _____

Did an ambulance/EMT provide you with care on the scene? ☐ No ☐ Yes

Did you ride in the ambulance? ☐ No ☐ Yes

Did you go to a hospital and receive care?

☐ No ☐ Yes (*where*): _____

Did you have any imaging taken (*Xray, MRI, CT, Etc.*)?

☐ No ☐ Yes (where): _____

Did you go to the Emergency Department or an Urgent Care facility at any time after the collision?

☐ No ☐ Yes (*where and when*): _____

Are you taking any medication for your pain/symptoms related to the collision?

☐ No ☐ Over the counter medication (*what kind, how much, how often*): _____

☐ Prescription medication (*what kind, how much, how often*): _____

How long after the collision did you feel pain?

☐ Immediately ☐ Within the first hour ☐ Later that night ☐ The next day ☐ Days later

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What bodily condition has brought you here today? _____

What do you need/want to be doing that your current condition is preventing you from?

_____

How long do you think recovery will take?

☐ Today ☐ Days ☐ Weeks ☐ Months ☐ Years ☐ I have no idea ☐ Other: _____

Would you describe your symptoms as:

☐ Getting worse ☐ Holding / Maintaining ☐ Getting better

How do your symptoms respond to your average daily routine?

☐ Worst in the morning ☐ Worse as the day progresses ☐ All day, same level ☐ Worse with a motion/posture

How often do you experience your symptoms?

☐ >75% of the time ☐ >50% of the time ☐ >25% of the time ☐ <25% of the time ☐ Only if I move the wrong/right way

Please, describe what your symptoms feel like:

☐ Painful ☐ Tight ☐ Tingling / Prickly ☐ Electric ☐ Numbness ☐ Unstable ☐ Disturbing

☐ Dull ☐ Dull, but Sharp if I move the wrong/right way ☐ Sharp

☐ Other (*describe it*): _____

What is the <u>most intense pain</u> you have experienced from this issue <u>in the past week</u>?

No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Unbearable

As you are reading this page, how intense is your pain <u>right now</u>?

No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Unbearable

What makes your symptoms <u>better</u>?

☐ Rest ☐ Laying down ☐ Sitting ☐ Standing ☐ Walking ☐ Stretching ☐ Exercise ☐ Ice / Cold ☐ Hot Pack

☐ Heating Pad ☐ Nothing ☐ Other: _____

What makes your symptoms <u>worse</u>?

☐ Looking up ☐ Looking down ☐ Lifting ☐ Bending ☐ Standing ☐ Walking ☐ Sitting ☐ Reaching Overhead

☐ Computer use ☐ Laying down ☐ Coughing ☐ Sneezing ☐ Going to the bathroom ☐ Nothing

☐ Other: _____

Are your symptoms affecting your activities at home?

☐ No ☐ Yes (*how or what*): _____

Are your symptoms affecting your activities at work?

☐ No ☐ Yes (*how or what*): _____

What forms of treatment have you received for your current symptoms?

☐ None ☐ Medical Doctor ☐ Prescription Medication ☐ Surgery ☐ Physical Therapy

☐ Chiropractic ☐ Acupuncture ☐ Massage ☐ Other: _____

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Do you currently have a primary care MD?

☐ No ☐ Yes (*who and where*): _____

Have you ever been treated by a chiropractor before?

☐ No ☐ Yes (*who and when*): _____

Have you ever been hospitalized (before the collision)?

☐ No ☐ Yes (*why and when*): _____

_____

Have you ever been in a car accident (before this collision)?

☐ No ☐ Yes (*why and when*): _____

_____

Have you had any surgical procedures performed?

☐ No ☐ Yes (*why and when*): _____

_____

Are you currently taking any vitamins or supplements?

☐ No ☐ Yes (*what kind, how much, how often*): _____

_____

Are you currently taking any medications (prescription and over the counter)?

☐ No ☐ Yes (*what kind, how much, how often*): _____

_____

Do you smoke or vape?

☐ No ☐ Not anymore (*what kind, how much, how often*): _____

☐ Yes (*what kind, how much, how often*): _____

Do you drink/take anything that contains caffeine (*coffee, soda, energy drinks, etc*)?

☐ No ☐ Yes (*what kind, how much, how often*): _____

Do you have annual physicals?

☐ No ☐ Yes

Do you have regular dental check-ups?

☐ No ☐ Yes

In your family (*yourself, children, siblings, parents, and grandparents*), is there a history of:

Cancer	(*who and type*): _____
Diabetes	(*who and type*): _____
Heart disease	(*who*): _____
High blood pressure	(*who*): _____
Scoliosis	(*who*): _____

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In the past 6 months, have you experienced (*leave blank if not applicable*):

Headaches	☐ Yes (*describe*): _____
Irregular bowel movements	☐ Yes (*describe*): _____
Nausea	☐ Yes (*describe*): _____
Lightheadedness	☐ Yes (*describe*): _____
Shortness of breath	☐ Yes (*describe*): _____
Chest pain or tightness	☐ Yes (*describe*): _____
Fainting	☐ Yes (*describe*): _____
Lost time	☐ Yes (*describe*): _____
Visual changes	☐ Yes (*describe*): _____
Difficulty swallowing	☐ Yes (*describe*): _____
Hearing changes	☐ Yes (*describe*): _____
Ear pain	☐ Yes (*describe*): _____
Jaw pain	☐ Yes (*describe*): _____
Shoulder pain	☐ Yes (*describe*): _____
Mood irregularities	☐ Yes (*describe*): _____
Numbness or tingling sensation	☐ Yes (*describe*): _____

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