



Auto Accident Intake Form – DeCubellis Family Chiropractic

Patient Name: _____

Date of Birth: _____

Date of Accident: _____

Date of First Visit: _____

Phone: _____

Email: _____

Section 1: Accident Details

- Location of accident (street/intersection): _____

- City/State: _____

- Type of accident:

☐ Rear-end ☐ Head-on ☐ Side impact ☐ Multi-car ☐ Other: _____

- Your position during accident:

☐ Driver ☐ Front passenger ☐ Rear passenger ☐ Pedestrian ☐ Other: _____

- Were you aware the crash was about to happen? ☐ Yes ☐ No

- Your vehicle's estimated speed at impact: _____ mph

- Other vehicle's estimated speed at impact: _____ mph

- Vehicle damage: ☐ Minor ☐ Moderate ☐ Major ☐ Totaled

- Were police called? ☐ Yes ☐ No Police report filed? ☐ Yes ☐ No

- Ambulance called? ☐ Yes ☐ No

- Hospital/ER visit? ☐ Yes ☐ No If yes, name: _____

- Treatment provided at hospital (check all that apply):

☐ X-rays ☐ CT/MRI ☐ Pain medication ☐ Discharged with instructions
☐ Other: _____

Section 2: Injuries & Symptoms

- **Primary areas of pain (check all that apply):**

☐ Neck ☐ Upper back ☐ Lower back ☐ Shoulders ☐ Headaches
☐ Jaw ☐ Hips ☐ Knees ☐ Numbness/Tingling ☐ Dizziness/Vertigo ☐ Other:

- **Describe the pain (select all that apply):**

☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Tingling ☐ Numbness
☐ Radiating ☐ Constant ☐ Intermittent

- **Pain levels (0 = no pain, 10 = worst imaginable):**

Neck: ____ /10 Back: ____ /10 Other: _____: ____ /10

- **Since the accident, symptoms have:**

☐ Improved ☐ Worsened ☐ Stayed the same

Section 3: Activities of Daily Living (ADLs)

Functional Rating Scale:

Score	Description
0	Fully Limited – Cannot perform at all
1–3	Severely Limited – Major difficulty, needs help
4–6	Moderately Limited – Can perform with difficulty
7–9	Mildly Limited – Some restriction
10	No Limitation – Same as pre-injury ability

Instructions:

Please check any activity impacted by your injuries and rate your **current ability** vs. **pre-injury ability**.

Activity	Affected? (✓)	Current Ability (0–10)	Pre-Injury Ability (0–10)
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Sleeping	<input type="checkbox"/>	_____	_____
Sitting	<input type="checkbox"/>	_____	_____
Standing	<input type="checkbox"/>	_____	_____
Walking	<input type="checkbox"/>	_____	_____
Driving	<input type="checkbox"/>	_____	_____
Working	<input type="checkbox"/>	_____	_____
Bending	<input type="checkbox"/>	_____	_____
Lifting	<input type="checkbox"/>	_____	_____
Carrying	<input type="checkbox"/>	_____	_____
Looking over shoulder	<input type="checkbox"/>	_____	_____
Reaching overhead	<input type="checkbox"/>	_____	_____
Showering	<input type="checkbox"/>	_____	_____
Bathing	<input type="checkbox"/>	_____	_____
Dressing	<input type="checkbox"/>	_____	_____
Climbing stairs	<input type="checkbox"/>	_____	_____
Household chores	<input type="checkbox"/>	_____	_____
Exercising	<input type="checkbox"/>	_____	_____
Childcare	<input type="checkbox"/>	_____	_____
Concentration/Focus	<input type="checkbox"/>	_____	_____
Social activities	<input type="checkbox"/>	_____	_____
Other (specify):	<input type="checkbox"/>	_____	_____

Section 4: Past Medical History

- **Prior similar symptoms before the accident?** ☐ Yes ☐ No
If yes, please explain: _____
 - **Previous chiropractic care?** ☐ Yes ☐ No If yes, when/why? _____
 - **Current medications (list all prescription or over-the-counter):**

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Section 5: Insurance & Legal Information

- **Do you have an attorney?** ☐ Yes ☐ No
Attorney Name: _____ Phone: _____
Law Firm: _____
 - **Your auto insurance provider:** _____
Claim number: _____ Adjuster name: _____
Medical Payments (MedPay) coverage? ☐ Yes ☐ No ☐ Unsure
 - **Do you have health insurance?** ☐ Yes ☐ No
 - **Other party's insurance provider (if known):** _____
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Section 6: Consent to Treat

I acknowledge that I am seeking chiropractic care as a result of an automobile accident. I authorize DeCubellis Family Chiropractic to evaluate and treat me and to release records to insurers, attorneys, or other relevant parties for the purpose of managing my care, billing, and legal documentation.

Patient Signature: _____ **Date:** _____
Guardian/Representative (if applicable): _____