Dr. Larry Gertler, M.Ed., D.C.

Automobile Accident In-Take Form for Patients

Date:_________________________

Patient Name:
Address:
Telephone:
Date of Birth:

History of Accident:

Date of Accident:
Your Driving Role: ☐ **Driver** ☐ **Passenger** ☐ **Front Seat** ☐ **Back Seat** (☐ **Driver's Side or** ☐ **Passenger Side)**
Vehicle Status: ☐ **Parked** ☐ **Moving** ☐ **Stopped at Stoplight <u>or</u> Stop Sign <u>or</u> Stopped in Traffic**
Impact Area on Car/Motorcycle:
Time of Day and Lighting Conditions:
Road Conditions:
Visibility:
Location of Accident (Street/Intersection/City/State):
Your Vehicle Type and Model:
Opposing Vehicle Type and Model:
Your Vehicle's Speed:
Opposing Vehicle Speed:
Your Vehicle's Headrest Position:

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History of Injury:

Body Location of Injury or Injuries:
Where do you have pain? ☐ **Head** ☐ **Neck** ☐ **Shoulder** ☐ **Arm/Wrist** ☐ **Hand/Fingers**
☐ **Hip** ☐ **Pelvis** ☐ **Leg** ☐ **Knee** ☐ **Foot/Toes/Ankle**
The nature of the pain is: ☐ **Consistent Pain** ☐ **Intermittent Pain** ☐ **Sharp** ☐ **Dull** ☐ **Throbbing** ☐ **Radiating**
☐ **Other:**

Your Insurance Company Information: ☐ **Medical** ☐ **Car**

Insurance Company's Name:	**Insured's Name:**
Address:	
Policy #:	**Claim #:**
Agent's Name and Phone #:	
Do you have a Med-Pay benefit?: ☐ **Yes** ☐ **No**	

Responsible Party's Insurance Company Information:

Responsible Party's Name:	
Insurance Company Name:	**Insured's Name:**
Address:	
Policy#:	**Claim #:**
Adjuster's Name and Phone #:	

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Additional Information:

Please explain any additional information that may be pertinent to your chiropractic visit with Dr. Gertler. Please include chronic or recent medical conditions and medications that you are taking:

Prior Treatment/Test Information:

Please list the medical/holistic exams, treatments or tests that you have had in the last 6 months (i.e., MRI, CatScan, Blood Tests, Xrays, Surgeries, etc.):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Please draw accident: