HEART IN HAND CHIROPRACTIC
Excellent Compassionate Healthcare

Athena Paradise, DC

Motor Vehicle Intake

PATIENT INFORMATION

Patient Name: Date:

Date of Accident: Time of Accident: ☐ a.m. ☐ p.m.

Please describe the accident in your own words:

Were you the: How many people were in the vehicle?

☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian ☐ Cyclist

ACCIDENT SITE

Road/Street Name:

City/State:

Nearest intersection with road/street:

Which direction were you headed? What speed were you traveling?

Driving Conditions:
☐ Dry ☐ Wet ☐ Icy ☐ Other:

YOUR VEHICLE

Make and model of the vehicle you were in:

Were you wearing a seatbelt? If yes, what type?
☐ Yes ☐ No ☐ Lap ☐ Shoulder

Was the vehicle equipped with airbags? If yes, did they inflate?
☐ Yes ☐ No ☐ Yes ☐ No

Did your seat have a headrest? If yes, indicate position of headrest:
☐ Yes ☐ No ☐ Low ☐ Middle ☐ High

IMPACT

Did your car impact another vehicle?
☐ Yes ☐ No

Did your car impact a structure? If yes, please explain:
☐ Yes ☐ No

Did any part of your body strike anything in the vehicle?
☐ Yes ☐ No

If yes to above question, please explain:

Was the impact from:
☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other:

At the time of impact, were you looking:
☐ Straight ahead ☐ To the right ☐ To the left ☐ Up ☐ Down

Were both hands on the steering wheel?
☐ Yes ☐ No

If no to above question, which hand was on the wheel:
☐ Right ☐ Left

Was your foot on the brake?
☐ Yes ☐ No

If yes to above question, which foot was on the brake?
☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE

Make and model of other vehicle (if applicable):

Which direction was the other vehicle headed?

At what speed was the other vehicle traveling?

POLICE

Did the police come to the accident site?
☐ Yes ☐ No

Were there any witnesses? Was a police report filed?
☐ Yes ☐ No ☐ Yes ☐ No

Was a traffic violation issued? If yes, to whom?
☐ Yes ☐ No

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PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long:

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital after the accident?
☐ Yes ☐ No

When did you go:
☐ Immediately after accident ☐ Next day ☐ 2 days or more after accident

How did you get to the hospital?
☐ By ambulance ☐ By private transportation

Name of hospital:

Name of doctor:

X-rays, MRI, CT, or other imaging performed?

Diagnosis:

Treatment received:

SYMPTOMS / INJURIES

Have you been able to work since this injury?
☐ Yes ☐ No

How many days of work have you missed?

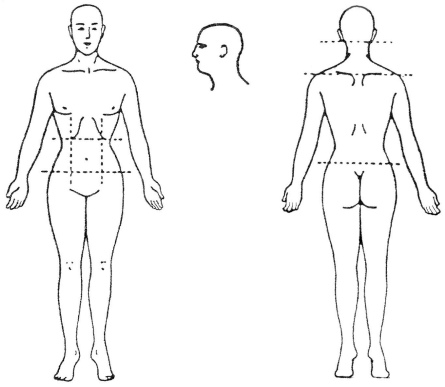
Prior to the injury, were you able to work on an equal basis with others your age?
☐ Yes ☐ No

Is this condition getting worse?
☐ Yes ☐ No ☐ Can't tell

If you have had any of the following symptoms since your injury, please place a check in the appropriate box:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Foot/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Muscle jerking
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Mark an X where you feel pain, burning, or tingling:



- Please rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain):
- Type of pain you're experiencing:

☐ Aching	☐ Dull	☐ Shooting	☐ Throbbing
☐ Burning	☐ Numbness	☐ Stiffness	☐ Tingling
☐ Cramps	☐ Sharp	☐ Swelling	☐ Other:

- How often do you have this pain?
- Is it constant or does it come and go?
- Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
- Painful movements: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent or Guardian: _____ **Date:** _____

Printed Name of Patient, Parent or Guardian: _____ **Relationship to Patient:** _____

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Heart in Hand Chiropractic - Dr. Athena Paradise, DC

Comparative Symptom Review Date of Accident/Injury: _____

Full Legal Name: _____ Date: _____

You will be asked to rate your symptoms both for intensity of the problem, and how often as a percentage of the day the symptom is present. Add notes if needed, i.e. if pain is constant but escalates later in the day: *100% and 3 in morning to 7 in evening*, or *only hurts during lifting*, etc. Use the following numeric scale.

0	1	2	3	4	5	6	7	8	9	10
None	**Mild** noticeable pain			**Moderate** Uncomfortable to distressing pain				**Severe** Severe to unbearable pain		
None	Minimal loss function			Significant loss motion or function				Marked to total loss function		

Indicate frequency as percentage of day 0-100%, if rare or intermittent state the triggering circumstance

Symptoms	Before Injury	Post Injury ___/___/___	Post Injury ___/___/___
Headache			
Neck pain or stiffness			
Mid-back pain			
Low back/buttock pain			
Chest or rib pain			
Abdominal pain			
Nausea/Vomiting			
Dizziness/Vertigo			
Ringing in Ears			
Depression			
Anxiety/Panic			
Fatigue / sleep changes			
Head feels heavy			
Jaw/TMJ problems	L R	L R	L R
Arm pain	L R	L R	L R
Shoulder pain	L R	L R	L R
Elbow pain	L R	L R	L R
Wrist/Hand pain	L R	L R	L R
Tingling down arm	L R	L R	L R
Numbness in arm/hand	L R	L R	L R
Leg pain	L R	L R	L R
Hip joint pain	L R	L R	L R
Knee pain	L R	L R	L R
Ankle/Foot pain	L R	L R	L R
Tingling down leg	L R	L R	L R
Numbness in leg/foot	L R	L R	L R
Weakness grip	L R	L R	L R
Weakness legs/balance			
Memory Difficulty			
Vision changes			
Light sensitivity			
Sound sensitivity			
Other			

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Motor Vehicle Accident Screening Checklist for Dr. Paradise

Please answer completely, take your time. Which of the following do you suffer from now which you did not before or is different than prior to the accident? If you previously had the symptom but it's now different since the accident, indicate what has changed.

Name: _____ Date: _____

- ☐ Headaches
- ☐ Long Term Memory Loss
- ☐ Loss of Consciousness
- ☐ Reading Problems
- ☐ Apathy
- ☐ Personality Changes
- ☐ Blurred or Double Vision
- ☐ Intolerance to Alcohol
- ☐ Impaired Comprehension
- ☐ Loss of Libido
- ☐ Concussion in Collision
- ☐ Extreme Thirst
- ☐ Tinnitus (ringing in ears)
- ☐ Bumping into Objects in View
- ☐ Hearing Loss
- ☐ Anxiety
- ☐ Flashback to Accident Scene
- ☐ Unusual Behavior
- ☐ Thoughts of Death/Suicide
- ☐ Blackouts with Neck Movement
- ☐ 'greying out' of Vision
- ☐ Loss of Bladder Control
- ☐ Jaw Pain
- ☐ Lower Back/Buttocks Pain
- ☐ Leg tingling or numbness
- ☐ Grip Weakness
- ☐ Bruising on Body, where? _____
- ☐ Dizziness
- ☐ Short Term Memory Loss
- ☐ 'blackouts' since Collision
- ☐ Writing Problems
- ☐ Irritability
- ☐ Emotional Difficulties
- ☐ Sensitivity to Light
- ☐ Intolerance to Heat
- ☐ Impaired Learning
- ☐ Missing Periods of Time
- ☐ Nausea
- ☐ Fatigue
- ☐ Sensitivity to Sounds
- ☐ Loss of Balance
- ☐ Vertigo (spinning feeling)
- ☐ Depression
- ☐ Intrusive Thoughts about the Accident
- ☐ Social Withdrawal
- ☐ Weight Loss/Gain ____lbs
- ☐ Dizziness with Neck Movements
- ☐ 'blacking out' of Vision
- ☐ Loss of Bowel Control
- ☐ Clicking in the Jaw
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Elbow/Forearm Pain
- ☐ Knee/Shin Pain
- ☐ Difficulty Concentrating
- ☐ Amnesia
- ☐ Forgetting passwords/PIN
- ☐ Typing Problems
- ☐ Sleep Disturbances
- ☐ Relationship Problems
- ☐ Vision Changes
- ☐ Intolerance to Cold
- ☐ Attention Impairment
- ☐ Speech Difficulties
- ☐ Vomiting
- ☐ Menstrual Irregularities
- ☐ Loss of Coordination
- ☐ Fluid in Ears
- ☐ Increased Symptoms in Crowds
- ☐ Change in Personality
- ☐ Nightmares since collision
- ☐ Panic Attacks
- ☐ Loss of Taste or Smell
- ☐ 'Clunk' sound with moving of neck
- ☐ Temporary Blindness
- ☐ Loss of Genital Sensation
- ☐ Pain with Chewing
- ☐ Upper/Middle Back Pain
- ☐ Arm Tingling or Numbness
- ☐ Wrist/Hand Pain
- ☐ Ankle/Foot Pain

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