

# Automobile Accident Intake

Bloom Chiropractic Center

Please answer all questions completely

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_

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**Minnesota is a no-fault injury state. Your treatment MUST go under your automobile insurance**

Your Auto Insurance Co. \_\_\_\_\_

Your Auto Ins. Address: \_\_\_\_\_

Your Claim #: \_\_\_\_\_ Your Policy # (found on your ins. card): \_\_\_\_\_

Claim Adjuster's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Have you retained an attorney?  No  Yes, if yes, list Name \_\_\_\_\_

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Date of the accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Describe in detail how the accident happened: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your vehicle was heading:  North  South  East  West

Other vehicle was heading:  North  South  East  West

Were the police notified?  No  Yes

Were you wearing a seatbelt?  No  Yes

How were you struck?  Behind  Front  Driver side  Passenger Side

You were the:  Driver  Passenger  Front Seat  Back Seat

**Proceed to Back Side**

Were you knocked unconscious?  No  Yes if yes for how long? \_\_\_\_\_

Did you feel pain immediately?  No  Yes

Did you see a doctor for treatment (other than today)?  No  Yes if yes, list below

Doctor's Name: \_\_\_\_\_  M.D.  D.C.  D.D.S

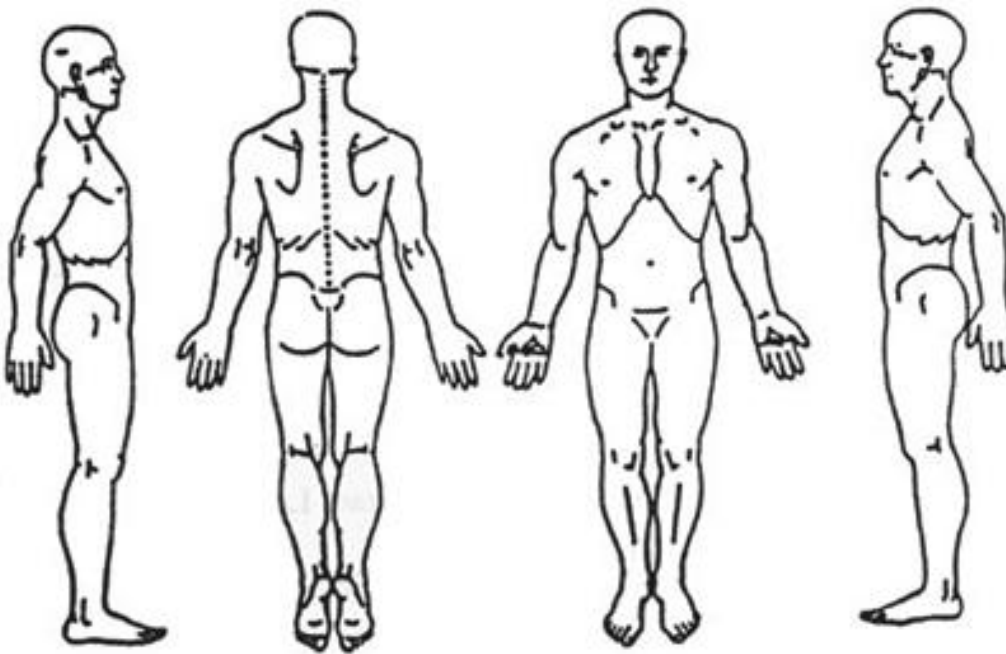
What was the diagnosis? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How often did you see the doctor? \_\_\_\_\_

How long did you see the doctor? \_\_\_\_\_

In the diagram below, mark on the body where you are currently feeling pain



Have you ever had any similar complaints before the accident?  No  Yes

If Yes, what were the complaints? \_\_\_\_\_

Are your work activities restricted as a result of the accident?  No  Yes

Since the accident, your symptoms are  Improving  Getting Worse  Same

By signing below, you agree that everything listed above was answered truthfully and to the best of your knowledge

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date