Bend Osteopathic Care, PC
147 SW Shevlin Hixon Drive, Suite 204, Bend OR 97702
Ph: 541 706-9985 & Fax: 541 408-9853

Motor Vehicle Accident Intake Form

Today's Date: _____ Name: _____ Date of Injury: _____

Insurance Information

Auto Insurance Company: _____ Address: _____
Claim Adjuster's Name: _____ Claim #: _____
Adjuster's Phone #: _____ Adjuster's Fax #: _____

Have you retained an attorney: ☐N ☐Y
Attorney's Name: _____ Attorney's Phone#: _____

Auto Accident Details

Date of Accident: _____ Time Occurred _____ ☐AM ☐PM
Year/Make/Model of vehicle you were in_____
Vehicles Owner: _____ Were you: ☐Driver ☐Passenger *(Where seated)*_____
Year/Make/Model of other vehicle(s) involved in collision: _____
Number of vehicles involved in collision: ☐1 ☐2 ☐3 ☐Other Number of people in your vehicle: _____
Location where accident occurred: _____ Intersection: _____
Road conditions at time of accident: ☐Wet ☐Dry ☐Clear ☐Rain ☐Snow ☐Ice ☐Other _____
Visibility: ☐Good ☐Fair ☐Poor ☐Sun Glare ☐Sunrise/Sunset ☐Dawn/Dusk ☐Other _____
Did your vehicle hit another vehicle: ☐N ☐Y Did Impact occur on your: ☐Rt Side ☐Lt Side ☐Rear ☐Front
Which of the following describes the accident: ☐Head on collision ☐Rear end collision ☐Broad-side collision
Other: _____ Did parts of the vehicle break: *(If yes what)* _____

Impact Details

Did you have forewarning of accident ☐N ☐Y Were you able to brace for impact: ☐N ☐Y
Speed of your car: _____mph Speed of other vehicle(s): _____mph
Hands at time of impact were located: _____ Feet at time of impact were located: _____
Head position at impact was:☐Straight ☐Turned Rt ☐Turned Lf **Body Position**:☐Straight ☐Turned Rt ☐Turned Lf
What parts of your Head/Body if any did you hit on inside of car: _____
Did you black out/go unconscious: ☐ *"or were you"* Shocked/Unclear of situation ☐ *"or"* Shaken/but Functional ☐
Were you wearing a seatbelt:☐N☐Y Do you have headrests:☐N ☐Y Do you have airbags:☐N ☐Y Deployed: ☐N ☐Y
Did Police Come: ☐N ☐Y Ambulance Come: ☐N ☐Y Go to the ER: ☐N ☐Y See your PCP: ☐N ☐Y
Xrays/MRI's: ☐N ☐Y Medications: ☐N ☐Y Diagnosis: ☐N ☐Y*(What)* _____ Treatments: ☐N ☐Y_____
Where did you go/who did you see: _____

Body Pain/Injury

How were you injured: _____
_____
When did the pain begin: _____ Other body parts affected: _____
Did you sustain bruises: ☐N ☐Y*(Where)* _____ Any bleeding cuts: ☐N ☐Y*(where)* _____
Please describe how you felt immediately after the accident: _____
How did you feel later that day/night:_____Feel the next day:_____
Were you able to get out of the vehicle: ☐N ☐Y Could you move all body parts: ☐N ☐Y *(If no, what parts and why)*
_____

General Symptoms (Since Accident Occurred)

✓	✓	✓	✓	✓
☐Neck Pain/Stiffness	☐Pins&Needles Legs	☐Numbness Toes	☐Constipation	☐Blurred Vision
☐Upper Back Pain	☐Pins&Needles Feet	☐Numbness Fingers	☐Diarrhea	☐Double Vision
☐Mid Back Pain	☐Dizziness	☐Cold Sweats	☐Bowel Changes	☐Other Vision Problems
☐Lower Back Pain	☐Headaches	☐Hot Sweats	☐Bladder Changes	☐Confused
☐Loss of Balance	☐Light Sensitivity	☐Fever	☐Fainting	☐Disoriented
☐Loss of Memory	☐Pain behind eyes	☐Fatigue	☐Seizures	
☐Pins&Needles Arms	☐Irritability	☐Sleep Difficulties	☐Forgetfulness	
☐Pins&Needles Hands	☐Depression	☐Nervousness/Anxiety	☐Ringing/buzzing/ears	
☐Heavy Head	☐Shortness of Breath			

Additional Questions

What is your best time of day/why: _____

What is your worst time of day/why: _____

What gives you the most relief: _____

Are you able to find a comfortable sleeping position: ☐N ☐Y*(Explain if no)* _____

Are you sleeping through the night: ☐N ☐Y Do you wake up in pain: ☐N ☐Y How many Hours sleep a night: _____

Has this changed since the accident: ☐N ☐Y *(If yes, how)* _____

Did you have a regular exercise routine before the accident: ☐N ☐Y Are you able to exercise now: ☐N ☐Y

Has your exercise routine changed because of the accident: ☐N ☐Y*(If yes, how)*_____

Have you missed any work due to the accident: ☐N ☐Y *(How much time missed)*_____ Does your job involve any of these: *Twisting*☐ *Bending*☐ *Lifting*☐ *Climbing stairs/ladder etc.*☐ *Sitting long periods*☐ *Standing long periods*☐ *Computer Work*☐ *Phones*☐ *Repetitive Work*☐ *Assembly Line/Factory Work*☐ *Neck/Eye Strain*☐ *Other*: _____

Has the accident impacted your ability to do household chores: ☐N ☐Y*(If yes, how)*_____

Have you had other types of treatment prior to coming here: ☐N ☐Y*(If yes, what treatments)*_____

How many treatments have you had:____Have these treatments given you relief: ☐N ☐Y How long does relief last: _____

On a scale of 1- 10 With 1 being No Pain and 10 being Extreme Pain, how would you rate your current level of pain *(Please Circle)*

No Pain ←1 2 3 4 5 6 7 8 9 10→ Extreme Pain

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Provider Initials: _____