Point to Health

A C U P U N C T U R E llc.
Danielle Quast LAc. M.Ac.OM, NTP
3804 SE Belmont Portland OR 97214
503-860-5009

Motor Vehicle Accident Intake

Today's date_____
Patient Name_____ Date of Injury_____
Address_____
Date of Birth_____Age_____SSN_____
Phone_____

Your Insurance Information:
Insurance Company Name_____
PIP Claim Adjusters Name_____
Claim Number_____
Claim Address_____
Phone_____
Describe the
accident_____
_____
_____
_____
_____
_____

Accident Information:
1. Were did the accident takplace?_____
2. Were you a passenger, or the driver?_____
3. Were you wearing a seatbelt? _____
4. Did the vehicle have a head rest?_____Was the head rest properly positioned?__
5. Were you pre-warned the accident was about to happen?_____
6. Do you have a clear recollection of the accident?_____
7. What was the speed of the vehicle at impact?_____
8. What kind of vehicle hit you?_____
9. What were you doing just prior to the accident?_____
10. What happened at impact?_____
11. What happened just after impact?_____
12. How did you feel emotionally and physically after the accident?_____
13. If no other car was involved, what did you hit?_____
14. Did your head whip back and forward forcefully?_____
15. Did you hear any popping, cracking, or snapping noises in your neck?_____
16. Did you have immediate pain after the accident?_____
17. Did any parts of your body strike part of the car (ex. Knees, chest)?_____
18. Did you have any bruising?_____

19. Were you rendered unconscious?_____
20. Did you go to the ER?_____
21. Were any x-rays taken?_____
22. Did you have any headaches following the accident?_____
23. If you did have a headache was it constant or did it come and go?_____
24. Do you have any pulsating, sharp pain, or pressure?_____
25. Have you had any dizzy spells since the accident?_____
26. Do you have any buzzing, or ringing in the ears?_____
27. Have you noticed any changes in your ability to remember, concentrate or think clearly since the accident?_____
28. Have you felt more irritable, or depressed since the accident?_____
29. How have you been sleeping?_____
30. Have you had any changes in energy level _____
31. Do you have any neck pain?_____
32. If so, what kind of pain and how often?_____
33. Have you noticed that you are restricted looking over your shoulder?_____
34. Do you have any pain down your arms?_____
35. Do you have any numbness in your hands?_____
36. Do you have any upper back pain?_____
37. If so, what kind of pain and how often?_____
38. Do you have any pain down your legs?_____
39. Do you have any abdominal pain?_____
40. Have you ever been in an auto accident before?_____
41. If yes, what was the date?_____
42 Have you ever been seriously ill?_____
43. Have you ever been hospitalized?_____
44. How is this affecting you at home?_____
45. How is this affecting you at work?_____

What was your body position at the time of the accident?
Head turned left___
Head turned right___
Looking back___
Head straight___
Body straight in sitting position___
Driver___
Passenger front seat____
Passenger back seat___
Other___

Please indicate your symptoms since the accident:
Headache___Ringing in ears___Loss memory___Depression___Dizziness___Numbness in fingers___Neck pain___Loss of balance___Nervousness___Fatigue___Cold sweats___ Numbness in toes___Neck stiffness___Loss of smell___Shortness of breath___Fainting___Cold hands___Cold feet___Eyes sensitive___Loss of taste___Irritability___Back pain___Chest pain___Sleep disturbances___Other___