Gaealana Healing Arts Center

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Auto Accident Intake Form

Name:____Date: ______________

Referred by: ____

Address: ____

Phone:____________________________________ Birthday: ________________________

Occupation:__________________________________ E-mail: _________________________

Emergency Contact:_____________________________ Phone:__________________________

Have you received massage therapy before?______________ If so what type?______________________

Would you like to receive our monthly e- newsletter with special offers? Yes ___ No___

Employment

At time of accident, where did you work? __________________________________ Unemployed ______

Where do you currently work? ____ Unemployed ______

If unemployed, is it due to injuries from the accident? Yes ___ No ___

What activities does your work require ? ____

Insurance

Insurance Company : ________________________________ Policy # :________________________

Insurance Contact Name : _____________________________ Claim #: __________________________

Insurance Company Address : ____

Insurance Phone #:__________________________________ Fax # :___________________________

Accident Details

Date of Injury: ____

You were: driver___ front passenger ___ rear passenger___ pedestrian ___bicyclist ___ other ______________

Your vehicle (yr./make/model)____

Your estimated speed at time of accident:_____ Were you: stopped ___ slowing ___ accelerating ___

Location/street ____

Direction of travel: N ___ E ___ S ___ W ___

Impact came from: Front ___ Rear ___ Left ___ Right ___ Other___________________________________

Other vehicle (yr./make/model)____

Time of day__________________

Road conditions: Dry___ Damp ___ Wet ___ Icy ___ Snow ___ Other_____________________________

During the accident :

Body position at impact:

Head: Forward___ Right ___ Left___ Up___ Down___ Unsure _____

Head Rest position: Up ____ Down ____ Unsure ____

Body: Forward ____Right ____Left ____Up ____ Down ____ Unsure __

Lap belt: On ____ Off ____ Shoulder Harness: On ____ Off ____

Aware of impending crash? Yes ____ No ____ Was seat broken by impact? Yes ____ No ____ Unsure ____

Was your vehicle equipped with an airbag? Yes ____ No ____ If yes, did it inflate? Yes ____No ____

Were you struck by the airbag? Yes____ No____ If yes, where were you struck? ______________________________

Did you strike any parts of the vehicle? Yes____ No ____ If yes, please describe_______________________________

____

Did your vehicle strike any objects after initial impact? Yes____ No____ If yes, please describe_________________

____

Was your vehicle pushed in any direction by the impact? Yes____ No ____ If yes, please describe________________

____

Were you wearing a hat or glasses before impact? Yes____ No ____

If yes, were they still on after the impact? Yes ____ No ____

Did the accident render you unconscious? Yes ____ No ____ If yes, for how long?_____________________________

After the accident:

Please describe how you felt immediately after the accident: ____

____

____

Were you seen by a doctor or did you go to a hospital after the accident? Yes ____ No ____

When did you go? Just after the accident ____ The next day ____ Days later ____ How many? ____

How did you get there? Ambulance ____Private transportation ____ Other : ____________________________________

Name of hospital and/or attending doctor: ____

Were X-rays taken? Yes ____ No____

Was medication prescribed? Yes ____No ____

Have you been able to work since the injury? Yes ____ No ____

Are your work activities restricted as a result of your injuries? Yes____ No ____

If yes, please describe ____

____

Were the police on the scene? Yes ____ No ____ Was an accident report filed? Yes ____ No ____

Estimated property damage to your vehicle : $_______________ None ____ Mild ____ Moderate ____ Major ____

Estimated property damage to other vehicle : $_______________ None ____ Mild ____ Moderate ____ Major ____

Other information about the accident you'd like to share ____

____

____

Please indicate all of the symptoms which you feel are a result of this accident.

____Neck pain
____Neck stiffness
____Jaw problems
____Headache
____Visual disturbances
____Auditory disturbances
____Numb feet/toes
____Numb hands/fingers

____ Chest pain
____Shortness of breath
____Shoulder pain
____Mid-back pain
____ Low back pain
____Leg pain
____Tingling in extremities
___Difficulty swallowing

____ Memory loss
____ Difficulty sleeping
____Irritability
____Disorientation/Confusion
____Nausea
____Fatigue
____Dizziness/Fainting
____ Loss of sense of smell

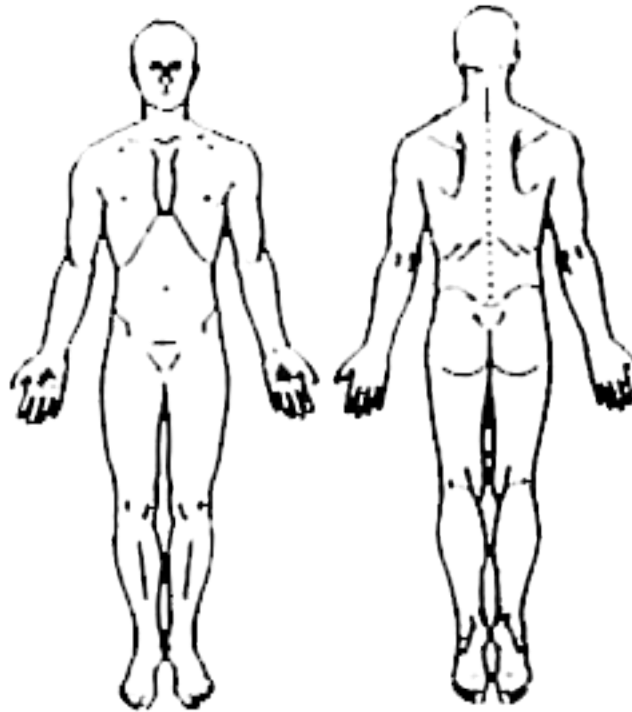
How long after accident did symptoms begin? ____

How frequent are the symptoms? ____

Please rate the severity on a scale from 1-10 (I = slight discomfort and 10 = extreme pain):________________

____

Mark all areas of current symptoms below:



To help evaluate the effect that your employment duties will have on your recovery, please indicate :

How many hours are in your normal work day?_______

Your daily job duties and any activities which you are occasionally asked to perform:

Daily: Standing ____ Driving ____ Operating equipment ____ Working with arms over head ____ Walking____

Lifting____ Sitting ____ Other ____

Occasional: Standing ____ Driving ____ Operating equipment ____ Working with arms over head ____

Walking ____ Lifting ____ Sitting ____Other ____

What positions can you work in with minimal physical effort & for how long?________________________

____

Informed Consent and Business Agreement

Full payment is expected at the time of service. A cancellation must be made 24 hours in advance to avoid charges. You are responsible for half the cost of an appointment canceled within 24 hours and full price of an appointment missed without cancellation. Payments must be made before receiving further treatment. In the case that you are using health or auto insurance to pay for a portion of your care in this office, arrangement may be made to omit payment to await reimbursement. We are often unable to predict these costs exactly, and may not know for 12 weeks up to 6 months after the date of service, once your company has processed the claim. By signing below, I accept financial responsibility for any outstanding charges that are not covered by my company and I authorize my provider, ______________________________, to release my medical records relating to claim for benefits submitted.

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I hereby give my consent to receive therapeutic massage.

Signature:____Date:______________________