A Renaissance Health Center for Natural Medicine
130 NW Miller Ave., Gresham, OR 97030 Phone: 503-665-2344 Fax: 503-665-2337

Motor Vehicle Injury Intake

Patient Name _____ Date _____
Address _____ City _____State ____ Zip Code _____
Phone: Home _____ Work _____ Cell_____
Birth Date _____ Age _____ Gender: M or F
Single _____ Married _____ Widowed _____
Occupation _____Employer _____
Employed at time of crash? Yes No Currently Employed? Yes No Unemployed due to crash? Yes No

Insurance Company _____
Insured's Name _____ Employer _____
Insured's ID Number _____ Insured's Birth Date _____

Claim Number for this accident _____
Adjuster's handling claim _____ Phone _____ Fax _____

Patient Information: Please circle the answers that most applies to you.

Crash Information:

Date and Time of crash? _____ Was the crash on the job? Yes No
You were: Driver Front seat passenger Rear seat passenger Motorcycle rider
Motorcycle passenger Other_____
Your vehicle (year, make, model): _____ Vehicle driven by: _____
Your estimated speed at moment of crash: Stopped Slowing Accelerating
Other vehicle (year, make, model) _____
Time of day: Dark Dawn Dusk Daylight
Road conditions: Dry Damp Wet Snow Ice Other_____
Head restraints: None Adjustable in up position Adjustable in down position Don't know
If adjustable, was the position altered by the crash? Yes No
Was the seat back altered by the crash? Yes No
Was the seat broken? Yes No
Lap belt: Wearing Not wearing Don't know
Shoulder belt: None Not wearing Wearing Don't know
Did the air bag deploy? Yes No
If yes, were you struck by the airbag? Yes No Where?_____
Body position? Upright Forward lean Other_____
Head position? Looking forward Looking up Head turned
Head tilted to side Other_____
Hands: One on wheel Two on wheel Holding arm rest N/A
Other_____
Brakes applied? Yes No
Where you aware of the oncoming crash? Yes No
Did you strike any part of your vehicle? Yes No If yes, describe_____
Did your vehicle strike any object after crash? Yes No If yes, describe_____
Wearing hat or glasses during crash? Yes No
If yes, still on after crash? Yes No
Did you lose consciousness? Yes No If yes, for how long? _____
Estimated property damage to your vehicle? $_____
Estimated damage to other vehicle? None Minimal Moderate Major
Were the police on-scene? Yes No
If yes, was a report made? Yes No

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Crash Diagram:

Crash Description:

_____
_____
_____
_____
_____
_____

After the Crash:

Symptoms: Headache Dizziness Nausea Confusion/disorientation
Neck pain Back pain Arm pain Leg Pain Numbness Tingling
Weakness If yes, where? _____
When did the symptoms first appear? Immediately _____hours after the crash
(Describe which symptoms) _____
Where did you go after the crash? Home Work Hospital Other_____
Mode of transportation? _____

Emergency Department:

X-rays: Yes No Body parts imaged_____ Results_____
Lab work: Yes No If yes, what labs_____
Treatment: Cervical collar Ice Medications_____
Other: _____
Follow up instructions: None Other _____

Treatment History:

Dr._____ Specialty: _____
Date first seen: _____ Referred by: _____
Treatment type: _____ Treatment frequency: _____
Treatment duration: _____ Currently treating? Yes No
Any disability? Yes No If yes, describe_____
Special tests: _____ Referred to: _____
Did treatment help? Yes No

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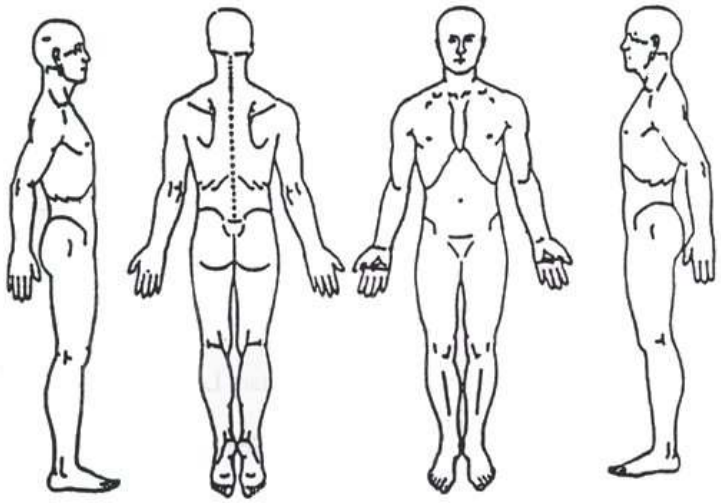
Is your condition getting: better _____ worse _____ same _____
Are your symptoms: constant _____ come and go ____ depends on activity _____
Did the pain appear: immediately ____ slowly over time ____ quickly after injury ____
Is it painful to: sit ____ stand ____ bend ____ walk ____ reach ____ climb stairs ____
get dressed _____ Getting in/out of car _____ lift ____ other _____
What have you used for this condition? Ice ____ heat ____ bed rest ____ wraps/braces ___ traction ___
Aspirin ____ Tylenol ____ Advil ____ other _____
How many times have you had this condition in the past? _____
List broken bones and when? _____
List motor vehicle crashes and when? _____
List surgeries and when? _____
List any allergies/ drug allergies? _____
List any medications, vitamins, pain killers, birth control pills _____
Are you pregnant? _____ How many months? _____ How many children and age? _____
How often do you use: Tobacco? _____ Alcoholic beverages? _____
Caffeinated beverages? _____ How often do you exercise? _____
Do you sleep on your back? ____ side? ____ stomach? ____ How many hours of sleep per night? _____

Please mark on the scale below your level of discomfort recently.

No Pain Severe Pain
0 ----------1 ----------2 ----------3 ---------4 ----------5 ----------6 ---------7 ----------8 ----------9 ----------10

Please circle your current areas of pain on the figures below:



Timothy Akita D.C.

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Please circle all that apply to you:

Recent infection
Recent fever
HIV/AIDS
Diabetes
Corticosteroid use
Arthritis
Stroke, Give Date _____
High blood pressure
High cholesterol/triglycerides
Dizziness/fainting
Urinary retention
Aortic aneurysm
Cancer/Tumor
Osteoporosis
Asthma
Hepatitis/Liver Disease
Rheumatic Fever
Irregular Moles
Persistent Cough
Multiple Sclerosis
Kidney Disease/ Stones
Pacemaker
Tuberculosis
Hands/feet: cold ____ hot ____
Stomach ulcer/bleeding ulcer
Prostate Problems

Frequent Urination
Abnormal Weight Gain/Loss
Epilepsy/Seizures
Visual Disturbances
Low Back Pain
Middle Back Pain
Neck Pain
Leg Pain or Numbness
Deafness/Hearing Aid
Pain At Night
Arm or Hand Numbness
Bleeding Disorder
Migraines/Many Headaches
Thyroid Disease
Sore That Won't Heal
Irregular Heartbeat/Murmur
Severe Menstrual Pain
Herpes/Shingles/Chicken Pox
Mononucleosis
Tinnitus
Rectal Bleeding
Shortness of Breath/Emphysema
Acid Reflux

Do you have a family history of the following? Who? Alive or deceased? If deceased, what age?

Cancer _____
Diabetes _____
High Blood Pressure _____
Cardiovascular Disease _____

Patient Signature _____ Date _____

Please leave for Dr. Akita to complete

Request records:

Request radiographs from: _____
Request records from: _____
Request copy of police report: _____

Referral:

For: _____ To: _____

Tests to order:

Radiographs: _____ CT: _____
MRI: _____ MRA: _____
Scintigraphy/SPECT: _____ Videofluoroscopy: _____
EMG/NCV: _____ Ultrasound: _____
Other: _____

Timothy Akita D.C.