Colner Family Chiropractic

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503.645.5810 www.ColnerFamilyChiropractic.com

Intake Form Instructions

For your convenience our new patient intake forms can be completed in a couple ways. Below are instructions on how to complete the forms as well as options on how to get them to us for processing.

Option #1

Fill out the forms on your computer and email them to us.

-complete the forms
-click on "File" at the top left of your web browser
-click on "Save As"
-give the document a name (eg. Your Name + New Patient Forms)
-save the document to your computers desktop
-attach the saved file to an email
-send email to drcolner@colnerfamilychiro.com

Option #2

Fill out the forms on your computer, print them at home and bring them with you.

-complete the forms
-click on "File" at the top left of your web browser
-click on "Print"

We have all of the forms in the office if you don't have access to a computer, the internet or a printer. If you need to fill them out in the office please plan on arriving 15 minutes prior to your scheduled appointment time.

Thank You!

Colner Family Chiropractic

CAD Injury History Form

General Information:

Patients name: ______________________________

Today's Date: ______________________________

Date Of Injury: ______________________________

General Injury History:

Was the crash on the job? ☐Yes ☐ No

You were: ☐ Driver ☐ Front Seat Passenger

☐ Rear Sear Passenger ☐ Motorcycle operator

☐ Motorcycle passenger ☐ Other: _____________

Vehicle Driven by: ___________________________

Your Vehicle (year, make model): ______________

Your estimated speed at the time of crash: ________

☐ Stopped ☐ Slowing ☐ Accelerating

Other Vehicle (year, make, model): _____________

Other Vehicle estimated speed at time of crash:______

Time of day: ☐ Dawn ☐ Daylight ☐ Dusk ☐ Dark

Road Conditions: ☐ Dry ☐ Damp ☐ Wet ☐ Snow

☐ Ice ☐ Other: ___________________________

Head Restraints: ☐ None ☐Integral Type

☐ Adjustable Type: ☐ up ☐ Down ☐ Don't know

If Adjustable, was position altered by crash: ☐Y ☐N

Was the seat back adj. altered by the crash:☐Y ☐N

Was the seat broken: ☐ Yes ☐ No

Lap Belt: ☐ Wearing ☐ Not wearing ☐ Don't know

Shoulder Belt: ☐ Wearing ☐ Not wearing ☐ None

☐ Don't know

Did air bag deploy: ☐ Yes ☐ No

If yes, were you struck: _______________________

Body Position: ☐ Good ☐ Forward Lean

☐ Other: _________________________________

Head Position: ☐ Forward ☐ Left ☐ Right ☐ Up

☐ Down

Hands: ☐ One on Wheel ☐ Two on Wheel

☐ N/A

Brakes Applied: ☐ Yes ☐ No

During the Crash:

Did you strike any parts of the vehicle: ☐ Yes ☐ No

I yes, describe:___________________________________

Did you strike any objects after crash: ☐ Yes ☐No

If yes, describe:________________________________

Wearing hat or glasses: ☐ 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(s): ☐ None

☐ Minimal ☐ Moderate ☐ Major

Were the police on scene: ☐ Yes ☐ No

If yes, was there a report made: ☐ Yes ☐ No

After the Crash:

Symptoms: ☐Headache ☐Dizziness ☐Nausea

☐Confusion/disorientation ☐Neck Pain ☐Back pain

☐Extremity Pain ☐Paresthesia(s) If yes, where: _______

When did SX first appear: ☐Immediately ☐____hrs later

Where did you go after crash: ☐Home ☐Work ☐Hospital

Mode of transport:______________________________

Pvt Dr.____

Emergency Department:

Radiographs: ☐ Yes ☐ No

Body parts imaged: ______________________________

Results____

Lab work: ☐ Yes ☐ No ☐ Cervical collar ☐ Ice

Medications: ___________________________________

Other:____

Follow-Up Instructions: __________________________

Crash Description: ______________________________
____
____
____
____

Crash Diagram:

Treatment History:

Dr. ____

Specialty: ________________ Date first seen:__________

Referred by: _______________ TX Type: _____________

TX frequency: ____________ TX Duration:____________

Currently treating: ☐ Yes ☐ No

Any disability: ☐ Yes ☐ No

If yes, Describe: __________________________________

Special Tests: ____________________________________

Referred to: ______________________________________

Did TX help: ☐ Yes ☐ No

Notes: ____
____
____

Claim Information:

Auto Insurance Company: __________________________

Address: ____

Claim #: ____

Adj. Name: ________________ Phone: ________________