BLACKWOOD FAMILY MEDICINE
1201 Lake James Dr. • Virginia Beach, VA 23464
Office: 757-523-0022 | Fax: 757-937-1326

Patient name: _____

MOTOR VEHICLE ACCIDENT
Patient Intake Questionnaire

Please complete this form before your visit. Your answers help your clinician understand the accident, your symptoms, and how your activities have changed. Check all choices that apply unless asked to choose one. Use “unsure” if you do not know and “not applicable” when appropriate. Attach extra pages if needed. A parent or caregiver may help complete the form.

Important symptoms that need immediate attention

Do not wait to finish this form if you have a worsening severe headache, repeated vomiting, a seizure, new weakness or numbness, increasing confusion, slurred speech, or difficulty staying awake after the accident. Call 911 or seek emergency care. If you are already in the office, tell staff immediately. Also tell staff immediately about trouble breathing, severe chest or abdominal pain, new loss of bladder or bowel control, numbness around the groin, or a painful or swollen leg after the accident.

Patient and visit information

Full name: _____ Date of birth: _____

Today’s date: _____ Appointment date: _____

Phone: _____ Preferred contact method: _____

Address: _____
_____

Emergency contact: _____ Relationship: _____ Phone: _____

Primary care clinician: _____ Phone: _____

Preferred language: _____ Interpreter needed? [ ] Yes [ ] No

Form completed by:

[ ] Patient [ ] Parent or guardian [ ] Other

If someone helped, name and relationship: _____

Do you need assistance with reading, hearing, vision, mobility, or completing this form?

[ ] No [ ] Yes — describe below

Main reason for your visit

What are the three most important symptoms or concerns you want addressed?

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Accident details

Accident date: _____ Time: _____ [ ] AM [ ] PM [ ] Unsure

Location or intersection: _____
_____

Vehicle type: _____ Approximate speed, if known: _____ mph

Your role (check one):

[ ] Driver [ ] Front passenger [ ] Rear passenger
[ ] Pedestrian [ ] Bicyclist [ ] Motorcyclist
[ ] Other: _____

Seating position (if applicable): _____

At impact, your vehicle was:

[ ] Stopped [ ] Moving [ ] Parked
[ ] Unsure [ ] Not applicable

Impact (check all that apply):

[ ] Front [ ] Rear [ ] Left side [ ] Right side
[ ] Rollover [ ] Multiple impacts [ ] Other: _____ [ ] Unsure

Safety equipment used (check all that apply):

[ ] Lap and shoulder belt [ ] Lap belt only [ ] Child safety seat [ ] Helmet
[ ] None [ ] Unsure [ ] Not applicable

Airbags deployed?

[ ] Yes [ ] No [ ] Unsure [ ] Not applicable

If yes, which airbags? _____ Did an airbag strike you? [ ] Yes [ ] No [ ] Unsure

Where were you looking?

[ ] Forward [ ] Left [ ] Right
[ ] Other: _____ [ ] Unsure

Did you see the collision coming or brace yourself?

[ ] Yes [ ] No [ ] Unsure

Did any part of your body strike something inside or outside the vehicle?

[ ] Yes [ ] No [ ] Unsure

If yes, which body part and what did it strike?

Were you thrown from the vehicle?

[ ] Yes [ ] No [ ] Unsure [ ] Not applicable

Were you trapped or helped out by rescuers?

[ ] Yes [ ] No [ ] Unsure

Could you walk at the scene?

[ ] Yes [ ] No [ ] With help [ ] Unsure

Did you have fainting, chest pain, dizziness, or another medical symptom before impact?

[ ] Yes [ ] No [ ] Unsure

If yes, describe symptom and when it began: _____

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In your own words, describe what happened and how your body moved during impact.

Estimates are acceptable. You do not need to determine fault to complete this form.

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Symptoms at the scene and care received

Did you hit your head or have a sudden jolt to your head or body?

[ ] Yes [ ] No [ ] Unsure

Did you lose consciousness or black out?

[ ] Yes [ ] No [ ] Unsure

If yes, estimated duration: _____ Was this witnessed? [ ] Yes [ ] No [ ] Unsure

Were you dazed, confused, or unable to remember part of the accident?

[ ] Yes [ ] No [ ] Unsure

Describe any memory gap, confusion, or change noticed by another person.

What symptoms or injuries did you notice immediately?

What symptoms appeared later? Include when they started.

Initial evaluation

Care at the scene (check all that apply):

[ ] None [ ] EMS evaluation [ ] Neck collar [ ] Other: _____

Transport (check one):

[ ] Ambulance [ ] Private vehicle [ ] Other: _____
[ ] No transport [ ] Transport advised but refused

First medical care date: _____ Facility: _____

Where were you first evaluated?

[ ] Emergency department [ ] Urgent care [ ] Medical office [ ] No prior evaluation

Hospital admission?

[ ] No [ ] Yes — dates: _____

Facility: _____

What diagnoses or injuries were you told you had?

Testing (check all that apply):

[ ] None [ ] X-rays [ ] CT
[ ] MRI [ ] Blood tests [ ] Other: _____

Body areas tested and results, if known: _____

What treatments, prescriptions, braces, or activity restrictions were provided?

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Care since the accident

List clinicians or facilities seen, dates, and treatments, including physical therapy, chiropractic care, counseling, injections, or surgery.

Treatment helped:

[ ] A lot [ ] Some [ ] Not at all
[ ] Made symptoms worse [ ] Unsure

Upcoming appointments or referrals: _____

Records available (check all that apply):

[ ] Discharge papers [ ] Imaging reports [ ] Medication list [ ] None

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Patient name: _____

Pain and physical symptoms

For each painful area, enter the side, when pain began, and pain scores. Use 0 for no pain and 10 for the worst pain imaginable. Compare with your usual pain before the accident.

Body area and side	Pain began date/time	Usual before 0–10	Now 0–10	Worst last 24 h 0–10

Pain feels (check all that apply):

[ ] Aching [ ] Sharp [ ] Burning [ ] Throbbing
[ ] Shooting [ ] Cramping [ ] Pressure [ ] Other: _____

Pain occurs:

[ ] Constantly [ ] Comes and goes [ ] With certain activities only

Since it began, pain is:

[ ] Improving [ ] Unchanged [ ] Worsening [ ] Varies

Does pain travel to another area, such as an arm or leg? Describe where and which side.

What makes symptoms worse? Include movements, positions, or activities.

What helps? Include rest, heat or ice, medicines, or other treatments.

Other physical symptoms — check symptoms you have now. Tell staff immediately about severe or worsening symptoms.

[ ] Neck stiffness [ ] Back stiffness [ ] Muscle spasm
[ ] Joint swelling [ ] Bruising [ ] Cuts or burns
[ ] Chest or rib pain [ ] Pain with breathing [ ] Abdominal pain
[ ] Shortness of breath [ ] Pelvic pain [ ] Trouble walking
[ ] None of these

For each checked symptom, describe location, start date, and whether it is new or worse than before the accident.

Have you had another injury or accident since this accident?

[ ] Yes [ ] No [ ] Unsure

If yes, date and details: _____

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Head injury, nerve symptoms, and emotional changes

For each row, check the description that best fits your symptoms now compared with before the accident. These questions describe symptoms and are not a diagnostic test.

Symptom	Not present	New	Present before and worse	Present before and unchanged
Headache	[ ]	[ ]	[ ]	[ ]
Dizziness or balance trouble	[ ]	[ ]	[ ]	[ ]
Nausea or vomiting	[ ]	[ ]	[ ]	[ ]
Blurred or double vision	[ ]	[ ]	[ ]	[ ]
Sensitivity to light or noise	[ ]	[ ]	[ ]	[ ]
Ringing ears or hearing change	[ ]	[ ]	[ ]	[ ]
Poor concentration or memory	[ ]	[ ]	[ ]	[ ]
Feeling slowed down or foggy	[ ]	[ ]	[ ]	[ ]
Unusual fatigue	[ ]	[ ]	[ ]	[ ]
Trouble sleeping or sleeping more	[ ]	[ ]	[ ]	[ ]
Irritability or mood changes	[ ]	[ ]	[ ]	[ ]
Anxiety, fear, or sadness	[ ]	[ ]	[ ]	[ ]
Nightmares or accident memories	[ ]	[ ]	[ ]	[ ]
Avoiding driving or riding	[ ]	[ ]	[ ]	[ ]

For new or worsened symptoms above, when did they begin and how do they affect you?

Numbness or tingling?

[ ] No [ ] Yes — location and side: _____

Weakness or dropping objects?

[ ] No [ ] Yes — location and side: _____

Problems with balance, falls, or walking?

[ ] No [ ] Yes — describe: _____

New bladder or bowel control changes or groin numbness?

[ ] No [ ] Yes [ ] Unsure

If yes or unsure, tell office staff immediately. Details:

How much emotional distress are you experiencing?

[ ] None [ ] Mild [ ] Moderate [ ] Severe

Do you feel safe at home?

[ ] Yes [ ] No [ ] Prefer to discuss privately

Would you like to discuss emotional concerns privately?

[ ] Yes [ ] No

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Health before the accident and medications

Before this accident, did you have pain or problems in any of the same areas? Describe symptoms, usual severity, activity limits, and last treatment.

List previous accidents, injuries, concussions, surgeries, or hospitalizations. Include dates and whether you had recovered before this accident.

Check conditions you have or have had:

[ ] Arthritis
[ ] Osteoporosis
[ ] Stroke
[ ] Diabetes
[ ] Kidney disease
[ ] Depression
[ ] Sleep disorder
[ ] Disc or spine problems
[ ] Migraine
[ ] Seizures
[ ] Heart disease
[ ] Liver disease
[ ] Anxiety
[ ] None
[ ] Chronic pain
[ ] Concussion or brain injury
[ ] Neuropathy
[ ] Lung disease
[ ] Bleeding disorder
[ ] PTSD
[ ] Other: _____

Details and other major conditions: _____

Could you be pregnant?

[ ] No [ ] Yes [ ] Unsure [ ] Not applicable

If yes, estimated weeks: _____ Pregnancy clinician: _____

Current medicines and allergies

List prescriptions, over-the-counter medicines, supplements, and accident treatments. Include aspirin, blood thinners, pain medicines, and sleep medicines. Attach a list if needed.

Medicine and strength	Dose and frequency	Started before/after accident	Benefit or side effects

Blood thinner or daily aspirin?

[ ] No [ ] Yes [ ] Unsure — name: _____

Drug allergies and reactions: _____ [ ] No known allergies

Other allergies, including latex or adhesives: _____

Tobacco or nicotine: _____ Alcohol: _____ Cannabis: _____

Other substance use relevant to care:

In the hours before the accident, did you use alcohol, cannabis, a sedating medicine, or another substance?

Patient name: _____

[ ] No [ ] Yes [ ] Unsure [ ] Prefer to discuss privately

If yes, substance, amount, and approximate time: _____

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Daily activities, work, and recovery

For each activity, mark how your ability now compares with before the accident. Mark N/A if you did not normally do that activity.

Activity	No new difficulty	Some new difficulty	Unable due to symptoms	N/A
Bathing, dressing, or personal care	[ ]	[ ]	[ ]	[ ]
Walking or climbing stairs	[ ]	[ ]	[ ]	[ ]
Sitting or standing	[ ]	[ ]	[ ]	[ ]
Lifting, carrying, or reaching	[ ]	[ ]	[ ]	[ ]
Housework or yardwork	[ ]	[ ]	[ ]	[ ]
Driving or riding in a vehicle	[ ]	[ ]	[ ]	[ ]
Sleeping through the night	[ ]	[ ]	[ ]	[ ]
Exercise, sports, or hobbies	[ ]	[ ]	[ ]	[ ]
Caring for children or others	[ ]	[ ]	[ ]	[ ]
Work or school tasks	[ ]	[ ]	[ ]	[ ]

Current sitting limit: _____ minutes Current standing limit: _____ minutes

Current walking limit: _____ minutes Hours slept per night: before _____ now _____

Waking from symptoms? [ ] Yes [ ] No

What help or equipment do you now need? Who is helping you?

Work and school

Status (check all that apply):

[ ] Employed [ ] Self-employed [ ] Student
[ ] Retired [ ] Not working

Job or school: _____ Usual hours per week: _____

Usual duties: [ ] Desk work [ ] Driving [ ] Standing [ ] Lifting Other duties: _____

Current status:

[ ] Usual duties [ ] Reduced hours [ ] Modified duties [ ] Unable to attend

Dates missed: _____ Return date, if any: _____

Restrictions already given and by whom: _____

Which tasks can you no longer do, or can do only with difficulty?

Do you need a work or school note?

[ ] Yes [ ] No [ ] Unsure

What barriers may affect treatment or recovery, such as transport, cost, time, or caregiving?

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Visit goals, claim details, and confirmation

Your goals and additional concerns

What activities would you most like to return to?

What questions or concerns would you like to discuss with your clinician?

Is there anything else that would help us understand your symptoms or care needs?

Optional insurance and accident claim information — complete if requested by the office. Write “unknown” if details are unavailable.

Health insurer: _____ Member ID: _____

Auto insurer: _____ Claim number: _____

Claim contact: _____ Phone: _____

Was the accident during work duties?

[ ] Yes [ ] No [ ] Unsure

If applicable, employer or workers compensation contact: _____

Police report available?

[ ] Yes [ ] No [ ] Unsure

Report number: _____

Attorney, if applicable: _____ Phone: _____

Providing an attorney’s name here does not authorize release of medical information. Any authorization to share records is handled separately.

Patient confirmation

I have answered to the best of my knowledge. If an answer is an estimate or I am unsure, I have indicated that. I understand that the clinician will review my answers with me.

Patient or parent/guardian signature: _____ Date: _____

Printed name and relationship, if applicable: _____

Office use only

Reviewed by: _____ Date and time: _____

Urgent concerns identified and action taken: _____

Records needed or requested: _____ _____

Patient name: _____

This is a general clinical intake questionnaire, not a validated disability or concussion scoring instrument. Head injury danger signs are adapted from CDC guidance: www.cdc.gov/traumatic-brain-injury/signs-symptoms/

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Patient name: _____

LIEN FOR DIRECT REIMBURSEMENT

Date of incident: _____

Patient's name: _____

Insurance company: _____

Claim number: _____

I do hereby authorize my insurance company listed above to pay directly to Blackwood Family Medicine such sums as may be due for medical services rendered to me by reason of this accident and any other bills that are due, and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate the provider.

I hereby further give a lien on my case to Blackwood Family Medicine against any and all proceeds of my settlement, judgment, or verdict that may be recovered or paid as the result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to Blackwood Family Medicine for all medical bills submitted for services rendered to me. This agreement is made solely for the provider's additional protection and in consideration for awaiting payment. I further understand that payment is not contingent on any recovery made by me. I hereby agree to waive the defense of statute of limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services were rendered. I agree to promptly notify the provider of any changes or additions to attorneys used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any substituted or added attorney.

I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest by signing this document, the provider will not await payment but may declare the entire balance due and payable at the time of service.

Date: _____ Patient signature: _____

Patient's printed name: _____
_____

Attorney name (if applicable): _____ Attorney signature: _____

Date: _____

Please review this lien carefully and ask our office any questions before signing.