Richard Duplantis MD*, DC, MA
Exclusively Licensed as a Doctor of Chiropractic
816A Harding St. Lafayette, LA 70503
(337) 350-0225
FAX (337) 628-1287

Personal Injury Intake Form

Please fill out all lines of this form. Details are important to assist in determining the extent of your injuries and treatment plan.

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Where did this accident occur? (Please include business name, street intersection, address, city, state if available)

_____

_____

Please describe in detail how the accident happened_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date of Accident _____ Time of Day _____AM/PM

Type of Accident: (Circle all that apply) *Head on Collision *Broad Side/"T-Bone" Collision *Front End Impact *Rear End Collision *Roll-Over Other_____

How many vehicles were involved: _____

Make, Model and Year of other vehicles involved: _____

Driver of Vehicle you were riding in/driving: _____

Who owns this Vehicle: _____

Make, Model, and Year of Vehicle: _____

Approximate Damage to Vehicle including $ estimate if known:

_____

Was the car you were driving/riding in drivable or towed away after the collision?

Drivable Towed- specify reason for towing (i.e. damage, lack of insurance, injury, impaired driver, other) _____

Were any other vehicles involved drivable or towed away after the collision?

Drivable Towed- specify reason for towing (i.e. damage, lack of insurance, injury, impaired driver, other) _____

Where was your car struck? (Circle all that apply) Front Rear Side Other_____

Were you the driver or a passenger: _____

If Passenger- Where in the vehicle were you seated: _____

Who else was in the vehicle and where were they seated:

_____

_____

_____

_____

Were any other passengers complaining of discomfort or injury at the time of the accident (please explain):

_____

_____

Road and Weather Condition at the time of the accident: (Circle all that apply)

Daylight Dark Raining Wet Slippery Icy Snow Clear Other: _____

Visibility at the time of the accident: (Circle One) Poor Fair Good Other:_____

Prior to impact, did you see that the accident was going to happen?

_____Yes _____No

If yes, Did you brace for impact? _____Yes _____No

If yes, How did you brace? _____

Were you wearing a seatbelt? _____Yes _____No

If yes, were you wearing the shoulder strap across your chest?
_____Yes _____No

If yes, how was the shoulder strap across your chest adjusted?
____Loose _____ Snug

Did the vehicle you were in have a headrest where you were seated?

_____Yes _____No

If yes, was the headrest adjusted for your height? _____Yes _____No

Does the vehicle have air bags? _____Yes _____No

If yes, Did the airbags deploy? _____Yes _____No

If yes, Which part of the vehicle had airbags deployed? _____

Was the car you were in stopped at the time of the accident? ____Yes ____No

Was the car you were in moving at the time of the accident? ___Yes ____No

If yes, how fast would you estimate your vehicle was moving? _____mph

How fast would you estimate the other vehicle was moving? _____mph

What position was your head/body in at the time of impact?

Head: Looking… (circle all that apply) Left Right Forward Backward Up Down Other- Please Explain _____

Body: Rotated/Leaning… (circle all that apply) Left Right Forward Backward Other- Please Explain _____

As a result of the accident you were: (circle all the apply)

Rendered Unconscious Shocked Dazed Confused

Hurting Immediately Other _____

Did you strike your head in the vehicle upon impact? _____Yes _____No

If yes, what part of your head hit the car and where on the car did it hit? (i.e. forehead hit dashboard)_____

Did any other part of your body strike the vehicle? _____Yes _____No

If yes, what part of your body hit the car?_____

Where on the car did your body hit during the accident?_____

Did any windows break during the accident? _____Yes _____No

If yes, which windows of the vehicle were broken? _____

Were you wearing a hat or glasses? _____Yes _____No

If yes, were they knocked off your head? _____Yes _____No

Could you move all parts of your body after the accident ____Yes _____No

If no, please describe _____

Were you able to get out of the car and walk unassisted? ____Yes _____No

If no, please describe _____

Did you have any bleeding or cuts as a result of the accident? ___Yes ___No

If yes, please describe _____

Was an ambulance dispatched to the scene? _____Yes _____No

If yes, were you evaluated by an EMT at the scene? _____Yes _____No

Were you taken to the hospital? _____Yes _____No

If yes, how were you taken to the hospital? _____Ambulance

_____Drove Self to Hospital ____Taken to Hospital by friend/family member

Please describe how you felt after the accident:

Immediately after the accident:

_____

_____

Later that day:

_____

_____

The Day after the accident:

_____

_____

Place a check mark next to symptoms apparent to you since the accident:

_____Headache _____Neck Pain/Stiffness

_____MidBack Pain _____Low Back Pain

_____Pain down back of leg (If yes, which leg or both) _____

_____Shoulder Pain _____Wrist Pain

_____Hand Pain _____Eye Light Sensitive

_____Pain Behind Eyes _____Dizziness

_____Fainting _____Trouble Sleeping

_____Numbness/Tingling in Fingers or Toes? If yes, specify_____

_____Loss of Smell/Taste _____ Jaw Pain

_____Loss of Memory _____Fatigue

_____Shortness of Breath _____Irritability

_____Depression _____Ringing/Buzzing in Ears

_____Loss of Balance _____Tension

_____Chest Pain _____Cold Sweats

_____Nervousness _____Foot/Ankle Pain

_____Cold Hands/Feet _____Diarrhea

_____Constipation _____Elbow Pain

Other problems or symptoms not mentioned above:

_____

_____

_____

Did you have any of these symptoms <u>prior to the accident</u>:

_____

_____

Did you have any previous X-Rays or Radiology Studies?

If yes, Where and approximate month/year(s)

_____

At any time since the accident have you lost control of your bladder or bowels
_____Yes _____No

If you did seek medical help immediately after the accident, how were you transported to the medical facility and by whom?

_____

Name of Hospital/Clinic _____

Name of Treating Physician _____

Date of first treatment after the accident _____

Were you examined by a medical professional?_____

Were X-Rays, CT's, or MRI's completed? _____

Did you receive treatment? _____

Were medications prescribed? _____Yes _____No

If yes, did you fill them and take them as prescribed? If no, why not?

_____

List medication prescribed and dosage/directions of when and how to take

_____

Did you seek medical help at a later time? _____Yes _____No

Name of Medical Professional or clinic_____

Your Occupation: _____

Employer: _____

Have you missed time from work due to this accident? _____Yes _____No

If you work full time, list time and dates missed _____

If you work part time, list time and dates missed _____

Auto Insurance Information:

Your Auto Insurance Company Name, Contact, Policy Number, and Claim#

_____

If you were not the driver, list the driver's Insurance Company Name, Contact, Policy Number, and Claim#

_____

_____

Did the driver of the other vehicle(s) involved have auto insurance? Y or N

Please list any information you have regarding the other driver(s), including insurance policy information

_____

_____

Have you been contacted by an insurance adjustor regarding this claim? Y or N

If yes, Name and Company of Adjustor:_____

Telephone Number and/or email of Adjustor:_____

Insurance Claim Number_____

Have you retained the services of an attorney?

If yes, please provide attorney name and contact information

_____

Do you have photos or video of the accident?

If yes, please forward by email to rickduplantismd@gmail.com

or text to Dr. Duplantis at 337-350-0225

Do you have an accident report? _____Yes _____No

Please provide us with a copy of your accident report once one is available to you.

My signature below signifies that all information provided is true and accurate. I agree that if my claim is deemed invalid, that I am personally and legally responsible for payment of services in full to Dr. Richard Duplantis LLC.

I understand that although payment to Dr. Duplantis may be deferred until settlement, that if this claim is closed and payment is not issued to Dr. Duplantis that I am personally and legally responsible for payment of services in full to Dr. Richard Duplantis LLC.

I further agree that I will notify Dr. Richard Duplantis LLC immediately if I should settle this claim on my own with the insurance company, or my attorney status changes (i.e. hire/fire attorney or retain a different attorney).

Print Name: _____

Signature: _____

Date: _____