

# Motor Vehicle Accident Information

Last Name:	Social Security no.:
First Name:	Middle:

## General Information

<b>Date of Accident:</b>			
<b>Location</b> (circle one)	<b>Driver</b>		
	<b>Passenger</b>	Location (circle one)	Front / Middle / Rear
		Position (circle one)	Left / Middle / Right

## Work from Left to Right and Circle One

<b>Patients Vehicle</b>	<b>Type :</b>	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	<b>Size :</b>	Mini / Sub Comp / compact / Mid Size / Full Size
	<b>Action :</b>	Stopped / Slowing / Acceleration / Cruising
	<b>Speed: (MPH)</b>	
	<b>Time of Accident:</b>	Day Light / Dawn / Dusk / Dark
	<b>Road Condition:</b>	Dry / Damp / Wet / Snow / Ice
	<b>Visibility:</b>	Good / Fair / Poor

*Enter impact Information for up to three Vehicles or Objects*

### Impact Information: Vehicle or Object (I)

<input type="checkbox"/> (Select one)	<b>Name Object :</b>	
<input type="checkbox"/> <b>Vehicle</b>	<b>Vehicle Type :</b>	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	<b>Size :</b>	Mini / Sub Comp / compact / Mid Size / Full Size
<input type="checkbox"/> <b>Object</b>	<b>Damage to Veh.:</b>	Minimal / Moderate / Extensive / Totaled / Unsure
<b>Impact Location</b>		

### Impact Information: Vehicle or Object (II)

<input type="checkbox"/> (Select one)	<b>Name Object :</b>	
<input type="checkbox"/> <b>Vehicle</b>	<b>Vehicle Type :</b>	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	<b>Size :</b>	Mini / Sub Comp / compact / Mid Size / Full Size
<input type="checkbox"/> <b>Object</b>	<b>Damage to Veh.:</b>	Minimal / Moderate / Extensive / Totaled / Unsure
<b>Impact Location</b>		

### Impact Information: Vehicle or Object (III)

<input type="checkbox"/> (Select one)	<b>Name Object :</b>	
<input type="checkbox"/> <b>Vehicle</b>	<b>Vehicle Type :</b>	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	<b>Size :</b>	Mini / Sub Comp / compact / Mid Size / Full Size
<input type="checkbox"/> <b>Object</b>	<b>Damage to Veh.:</b>	Minimal / Moderate / Extensive / Totaled / Unsure
<b>Impact Location</b>		

### During Impact Information:

Seat Belt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brakes Applied ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Air Bag Deployed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seat Broken ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seat Back position Changed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Head Rest : (Circle one)	Low / Mid / High / None
Prepare for Accident: (Circle One)	Un-expected / Expected / Expected and Braced
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Thrown?	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Direction of Throw :(Circle One)	Backwards / Forward / Outside / Unsure / Other:

(Circle One)

Head Position :	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion :	Forward Backwards / Backwards Forward / Right Left / Left Right / Unsure / Other:

### Body Impact (Indicate any parts of your body that were struck during the impact)

<input type="checkbox"/> Head	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Right hand	<input type="checkbox"/> Lower Back
<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Left Leg	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Right Foot
<input type="checkbox"/> Left Arm	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Mid Back	<input type="checkbox"/> Left Foot
<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right Knee	<input type="checkbox"/> Other :
<input type="checkbox"/> Left hand	<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Knee	
<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Right Elbow	<input type="checkbox"/> Lower Front Torso	

### After Accident Information:

Immediately After Accident:	<input type="checkbox"/> Dizzy/dazed <input type="checkbox"/> Upset <input type="checkbox"/> Weak <input type="checkbox"/> Nervous <input type="checkbox"/> Headache <input type="checkbox"/> Disoriented <input type="checkbox"/> Unconscious
	<input type="checkbox"/> /Other:

### Pain (Indicate if you experienced any pain immediately following the accident)

<input type="checkbox"/> Head	<input type="checkbox"/> Left foot	<input type="checkbox"/> Right foot	<input type="checkbox"/> Left Knee
<input type="checkbox"/> Left Hand	<input type="checkbox"/> Left Shoulder	<input type="checkbox"/> Right Shoulder	<input type="checkbox"/> Right knee
<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Elbow	<input type="checkbox"/> Left Arm	<input type="checkbox"/> Other :
<input type="checkbox"/> Upper Front Torso	<input type="checkbox"/> Mid Torso	<input type="checkbox"/> Right elbow	
<input type="checkbox"/> Upper Back	<input type="checkbox"/> Mid back	<input type="checkbox"/> Lower Front Torso	
<input type="checkbox"/> Left Leg	<input type="checkbox"/> Right Leg	<input type="checkbox"/> Lower Back	

<b>Numbness:</b>	<input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand <input type="checkbox"/> Left Leg <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Upper Arm
	<input type="checkbox"/> Right Upper Arm <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Foot <input type="checkbox"/> Other:

### Medical Information (Did you get medical care for this accident before coming to our office)

Medical Care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other:(Specify)
Admitted to Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No Days Spent in Hospital:
Test:	<input type="checkbox"/> X-ray <input type="checkbox"/> Lab Work <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Other:(Specify)
Treatment:	<input type="checkbox"/> Ice Pack <input type="checkbox"/> Hot Pack <input type="checkbox"/> None <input type="checkbox"/> Cervical Collar <input type="checkbox"/> Medication <input type="checkbox"/> Other:(Specify)

## Previous Injuries

Previous Injuries / Accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:
Residual pain from Previous Injuries/Accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes, Specify:

## Later Symptoms (Please note any symptoms that started after the accident occurred)

Head	<input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Light Headedness <input type="checkbox"/> Loss of Vision <input type="checkbox"/> Fainting <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Pain in ear <input type="checkbox"/> Double Vision <input type="checkbox"/> Other Specify:
Neck (with Movement)	<input type="checkbox"/> Pain in Neck <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Turn Left <input type="checkbox"/> Popping in Neck <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Turn Right <input type="checkbox"/> Bend Left <input type="checkbox"/> bend Right <input type="checkbox"/> Other Specify:
Shoulders	<input type="checkbox"/> Pain in Shoulder joint <input type="checkbox"/> Tension in shoulders <input type="checkbox"/> Muscle Spasms in Shoulder <input type="checkbox"/> Pain across shoulder <input type="checkbox"/> Cant raise arms above [ ] Above shoulder level [ ] Over head <input type="checkbox"/> Other Specify:
Arms and Hands	<input type="checkbox"/> Pain in Fingers <input type="checkbox"/> Numbness in Left Arm <input type="checkbox"/> Hands Cold <input type="checkbox"/> Pin & needles in hands <input type="checkbox"/> Numbness in Right Arm <input type="checkbox"/> Loss of Grip Strength <input type="checkbox"/> Pin & needles in fingers <input type="checkbox"/> Swollen joints in Fingers <input type="checkbox"/> Other Specify:
Chest	<input type="checkbox"/> Chest pain <input type="checkbox"/> Pain Around Ribs <input type="checkbox"/> Shortness of Breadth <input type="checkbox"/> Breast Pain <input type="checkbox"/> Other Specify:
Abdomen	<input type="checkbox"/> Nervous Stomach <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Other Specify:
Mid back	<input type="checkbox"/> Sharp Stabbing <input type="checkbox"/> Mid pain back <input type="checkbox"/> Pain From front to back <input type="checkbox"/> Dull Ache <input type="checkbox"/> Pain in Kidney Area <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Other Specify:
Lower Back	<input type="checkbox"/> Low Back Pain Low back pain is worse when <input type="checkbox"/> Working <input type="checkbox"/> Lifting <input type="checkbox"/> Stooping <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Lying Down <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Other Specify:
Hips, Legs & Feet	<input type="checkbox"/> Pain in Buttocks <input type="checkbox"/> Pain and needles in Legs <input type="checkbox"/> Pain down leg <input type="checkbox"/> Pain in hip joint <input type="checkbox"/> Feet feel Cold <input type="checkbox"/> Swollen Feet <input type="checkbox"/> Numbness in Toes <input type="checkbox"/> Numbness of Leg <input type="checkbox"/> Knee pain <input type="checkbox"/> Leg cramps <input type="checkbox"/> Cramps in Feet <input type="checkbox"/> Other Specify:
General	<input type="checkbox"/> Nervousness <input type="checkbox"/> Fatigue <input type="checkbox"/> Irritable <input type="checkbox"/> Depressed <input type="checkbox"/> Generally Feel Rundown <input type="checkbox"/> Prostate Pain/Swelling <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Night Urination <input type="checkbox"/> Cramping <input type="checkbox"/> Irregularity Loss of Sleep : [ _____ ] hrs per night Loss of weight : [ _____ ] lbs Gain weight : [ _____ ] lbs Other:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.