

Motor Vehicle Accident Information

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

Last name:	First:	Middle:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one) Single / Mar / Div / Sep / Widow	
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.		
			Birth date:		Age:	Sex:
Street address:			DL#:		Home phone:	
P.O. box:		City:		State:		ZIP Code:
Occupation:		Employer:		Employer phone:		

General Information

Date of Accident: _____

Location (circle one)	Driver	Location (circle one)	Front	/	Middle	/	Rear
	Passenger	Position (circle one)	Left	/	Middle	/	Right

Work from Left to Right and Circle One

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

Enter impact Information for up to three Vehicles or Objects

Impact Information: Vehicle or Object (I)

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

Impact Information: Vehicle or Object (II)

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

Impact Information: Vehicle or Object (III)

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

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

<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:
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Pain

<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	

Numbness:	<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:
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Medical Information

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

Later Symptoms

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: _____

Later Symptoms Contd:

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"/> Prostrate Pain/Swelling <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Night Urination <input type="checkbox"/> Cramping <input type="checkbox"/> Irregularity
	Loss of Sleep : [_____] hrs
	Loss of weight : [_____]lbs
	Gain weight : [_____] ibs
	Other: _____

Patient Signature: _____

Date: _____