Family Friendly Chiropractic

Thank you for carefully answering each question!

Patient: Black ink,
Doctor: Red ink

Patient Name: _____ **Date:** _____

Motor Vehicle Accident Health History Form (*Page 1*):

Date of the accident:_____. Approximate time of the accident:_____.

Your Vehicle

What is the make & model of your car/truck? _____ What is the year? _____

Were you the: ∟ Driver ∟ Front right passenger ∟ Front middle passenger ∟ Rear passenger, driver's side ∟ Rear passenger, right side ⌟ Rear middle passenger ∟ Other:_____

At the time of the accident what kind of surface were you driving on? ∟Dry pavement. ∟Wet pavement. ∟Gravel. ∟Dirt. ∟Other: _____.

Were you restrained by a seatbelt? ∟No. ∟Yes. If yes, what kind? ⌟ Shoulder and lap belts ⌟ Shoulder only ∟ Lap only

Did your seat have a headrest? ⌟No. ∟Yes. Where was the top of the headrest positioned in relation to the top of your head? ∟ above my head ⌟ below my head ⌟ level with my head

Do you recall how far your headrest was from the back of your head? ∟No. ∟0-1 inches. ⌟1-3 inches. ∟3 or more inches.

The Other Vehicle(s)

How many vehicles struck your car/truck?_____ If more than 1 please ask for another sheet of paper and answer the questions in this table for each vehicle.

What is the make & model of their car/truck? _____ What is the year? _____

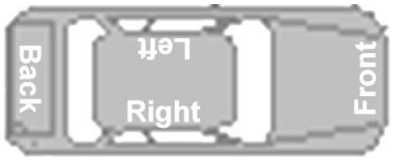
The Accident

Approximately how fast were you going at the time of impact?_____mph. Approximately how fast was the other car going at the time of impact?_____mph. About how far did your car move after being struck?_____feet.

If you were car was standing still at the point of impact, where was your foot or feet? ∟Pressed on the brake. ∟Resting on the break. ⌟off the break.

Where was your head facing when the collision occurred? ∟Looking right at rear view mirror. ⌟Looking right through a window. ∟Looking left through a window. ⌟Looking right through back window. ∟Looking up. ∟Looking down.

On the diagram to the right, please mark the point(s) of impact on to your vehicle.



Which direction did the striking vehicle come from? ∟Head on (from front). ⌟From behind. ∟From right. ⌟From left. ∟Diagonal or obliquely from:_____

After the accident did you strike anything else? ∟No. ⌟Yes. If yes, describe:_____

Was there any damage done to **your** vehicle? ∟No. ⌟Yes. If yes, how extensive:_____

Was there any damage done to the **other** vehicle? ⌟No. ∟Yes. If yes, how extensive:_____

Did your airbags deploy? ∟No. ⌟Yes. If yes, which airbags:_____

Did the police arrive? ∟No. ∟Yes. If yes, was a report made?_____

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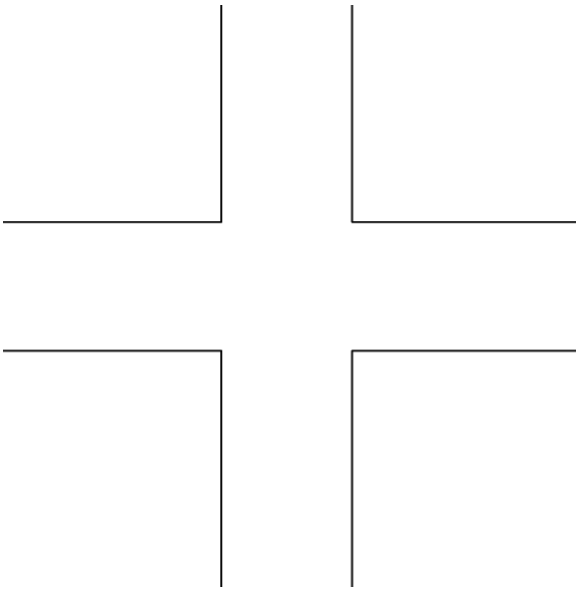
Patient Name: _____ **Date:** _____

Motor Vehicle Accident Health History Form (Page 2):

The Accident, in your words:

Below please describe in your words how the accident occurred, use the diagram of an intersection if helpful:



Injuries:

Were you aware of the collision as it occurred? ⌟No. ⌞Yes.

If yes, then did you brace your arms and legs? ⌞No. ⌟Yes.

Did you lose consciousness at any point during or after the collision? ⌟No. ⌞Yes.

Were you ejected from the vehicle? ⌟No. ⌞Yes. If yes, describe:

Did any part of your body strike the interior of your vehicle? ⌟No. ⌟Yes. If yes explain:_____

_____.

Did you sustain any injuries occur outside of your vehicle? ⌞No. ⌟Yes. If yes explain:_____

_____.

Did you have any pain as a result of the collision? ⌟No. ⌞Yes. If yes explain:_____

_____.

Did you suffer any bruises, cuts, or broken bones from the collision? ⌞No. ⌟Yes. If yes explain:_____

_____.

Did you suffer any of the following symptoms (mark all that apply)? ⌟Dizziness. ⌟Light headedness. ⌞Severe headache. ⌞Vertigo. ⌞Blurry vision. ⌟Confusion. ⌟Memory loss. ⌟Extreme drowsiness. ⌞Difficulty with focus or concentration. ⌞Sensitivity to light. ⌟Visual disturbances. ⌟Nausea. ⌟Vomiting. ⌞Muscle weakness. ⌞Numbness or tingling. ⌟Ringing in ears. ⌞Difficulty sleeping. ⌟Difficulty with speech. ⌟Feelings of depression or sadness. ⌞Feelings of nervousness or anxiety. ⌟Crying for no reason. ⌟Other:_____.

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Patient Name: _____ **Date:** _____

Motor Vehicle Accident Health History Form (*Page 3*):

Medical History

Did you go to the hospital after the accident? ⌟No. ∟Yes. If yes, please answer the five questions below:

1. Did you travel by: ∟Ambulance? ∟Your car? ∟Another car?
2. How long after the accident did you arrive at the hospital?_____
3. How did you leave the hospital? ∟Someone drove me. ∟I drove myself.
4. Were x-rays or other imaging procedures performed? ⌟No. ⌟Yes. If yes, explain:_____
5. Did you receive treatment or any prescription/medications at the hospital? ∟No. ⌟Yes. If yes, explain:_____

_____

Other than the hospital, have you visited any other health care providers since the accident? ∟No. ⌟Yes. If yes, explain (include names and phone numbers):_____

_____.

Have you ever been involved in a motor vehicle accident before? ⌟No. ⌟Yes. . If yes, please answer the five questions below:

1. When and where did the accident(s) occur? *If more than 3, please ask for another sheet of paper*
   a. _____
   b. _____
   c. _____
2. Who did you see for care? *If more than 3, please ask for another sheet of paper*
   a. _____
   b. _____
   c. _____
3. What type of care did you receive? *If more than 3, please ask for another sheet of paper*
   a. _____
   b. _____
   c. _____
4. Did all of your symptoms resolve from the above mentioned accidents? ⌟No. ∟Yes. If not, what symptoms persisted?_____
   Did any remaining symptoms affect your daily activities in any way? ⌟No. ∟Yes. If yes, explain:_____

_____

Impact on Your Life:

Please mark the activities below that have been adversely affected, or are difficult to perform, since your motor vehicle accident.

Domestic Activities:

☐ Cleaning	☐ Folding laundry	☐ Moving items	☐ Standing
☐ Cooking	☐ Getting into/out of bed	☐ Lifting objects	☐ Vacuuming
☐ Eating	☐ Holding bowls or cups	☐ Sitting down	☐ Other:

Personal Care Activities:

☐ Combing hair	☐ Nail care	☐ Toilet care	☐ Shaving
☐ Brushing teeth	☐ Showering	☐ Bathing	☐ Gargling
☐ Applying makeup	☐ Shampooing hair	☐ Dressing	☐ Other:

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Patient Name: _____ **Date:** _____

Motor Vehicle Accident Health History Form (Page 4): _____

Relationship Activities:

☐ Hugging	☐ Laughing	☐ Sexual activity	☐ Other:
☐ Kissing	☐ Holding hands	☐ Personal relationships	

Child Care Activities:

☐ Carrying your child	☐ Bathing your child	☐ Packing lunch	☐ Pushing a stroller
☐ Changing diapers	☐ Breast feeding	☐ Picking up your child	☐ Toweling after bath
☐ Washing/shampooing	☐ Bottle feeding	☐ Playing with your child	☐ Other
☐ Entertaining your child	☐ Rocking your child	☐ Hugging your child	

Sports & Athletic Activities:

☐ Aerobics	☐ Football	☐ Racquet sports	☐ Table tennis
☐ Archery	☐ Golf	☐ Rafting	☐ Tennis
☐ Baseball	☐ Gymnastics	☐ Rollerblading	☐ Walking
☐ Badminton	☐ Handball	☐ Rock climbing	☐ Waterskiing
☐ Basketball	☐ Horseback riding	☐ Roller skating	☐ Weight training
☐ Biking	☐ Hunting	☐ Rugby	☐ Wind surfing
☐ Boogie boarding	☐ Ice skating____	☐ Soccer	☐ Working out
☐ Bowling	☐ Jet skiing	☐ Softball	☐ Wrestling
☐ Camping	☐ Jogging	☐ Snowmobiling	☐ Volleyball
☐ Canoeing	☐ Martial arts	☐ Snowboarding	☐ Yoga
☐ Cross country skiing	☐ Mountain biking	☐ Surfing	☐ Other:_____
☐ Down hill skiing	☐ Pilates	☐ Swimming	_____

Social Activities:

☐ Religious practices	☐ Movies	☐ Shopping	☐ Going out
☐ Picnics	☐ Eating out	☐ Music events / concerts	☐ Reading
☐ Sightseeing	☐ Entertaining	☐ Dancing	☐ Other:_____
☐ Visiting friends/relatives	☐ Vacationing	☐ Walking	_____

General Household Activities:

☐ Mowing the lawn	☐ Yard work	☐ Car maintenance	☐ Shoveling snow
☐ Fertilizing	☐ Clearing brush	☐ Washing car	☐ Taking out the trash
☐ Tree trimming	☐ Raking	☐ Using tools	☐ Walking the dog
☐ Watering the lawn	☐ Cleaning the gutters	☐ Painting	☐ Caring for pets
☐ Weeding	☐ Spraying	☐ Hammering	☐ Other

Activities that Impact your Career:

☐ Attendance at work	☐ Grasping actions	☐ Prolonged walking	☐ Stairs
☐ Performance at work	☐ Group tasks	☐ Perform required tasks	☐ Telephone operation
☐ Bending activities	☐ Heavy work	☐ Pushing actions	☐ Tool operation
☐ Bookkeeping	☐ Keyboarding	☐ Pulling actions	☐ Transportation to work
☐ Communication	☐ Lifting objects	☐ Reaching actions	☐ Writing
☐ Concentration	☐ Machine operation	☐ Reading	☐ Working on a computer

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Patient Name: _____ **Date:** _____

Motor Vehicle Accident Health History Form (Page 5): _____

☐ Data entry	☐ Memory	☐ Repetitive motion	☐ Other:_____
☐ Driving	☐ Operating a mouse	☐ Safety is affected	_____
☐ Fine visual work	☐ Prolonged sitting	☐ Shoulder checking	_____
☐ Forceful exertion tasks	☐ Prolonged standing	☐ Speech	

General Movement Activities:

☐ Movements requiring neck strength or motion	☐ Movements requiring upper back strength or motion
☐ Movements requiring mid back strength or motion	☐ Movements requiring lower back strength or motion
☐ Movements requiring hand strength or motion	☐ Movements requiring wrist strength or motion
☐ Movements requiring elbow strength or motion	☐ Movements requiring shoulder strength or motion
☐ Movements requiring hip strength or motion	☐ Movements requiring knee strength or motion
☐ Movements requiring ankle strength or motion	☐ Movements requiring foot strength or motion

Oswestry Disability:

This questionnaire has been designed to give us information as to how your back or leg pain is affecting you ability to manage everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We do realize that two or more options may apply, but please only select one. Thank you

Section 1: Pain Intensity

☐I have no pain at the moment ☐The pain is very mild at the moment ☐The pain is moderate at the moment ☐The pain is fairly severe at the moment ☐The pain is very severe at the moment ☐The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. Washing, dressing)

☐I can look after myself normally without causing extra pain ☐I can look after myself normally but it causes extra pain ☐It is painful to look after myself and I am slow and careful ☐I need some help but can manage most of my personal care ☐I need help everyday in most aspects of self-care ☐I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

☐I can lift heavy weights without extra pain ☐I can lift heavy weights but it gives me extra pain ☐Pain prevents me from lifting heavy objects off of the floor, but if it conveniently placed (eg. table) ☐Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned ☐ I can only lift very light weights ☐I cannot lift anything

Section 4: Walking

☐Pain does not prevent me from walking any distance ☐Pain prevents me from walking more than 2 miles ☐Pain prevents me from walking more than 1 mile ☐Pain prevents me from walking more than ½ a mile ☐I can only walk using a stick or crutches ☐I am in bed most of the time, and try to avoid walking

Section 5: Sitting

☐I can sit in any chair for as long as I would like without any extra pain ☐I can only sit in my favorite chair for as long as I would like ☐Pain prevents me from sitting for more than one hour ☐Pain prevents me from sitting for more than 30 minutes ☐ Pain prevents me from

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Patient Name: _____ **Date:** _____

Motor Vehicle Accident Health History Form (Page 6):

sitting for more than 10 minutes ☐Pain prevents me from sitting at all

Section 6: Standing

☐I can stand for as long as I would like without any extra pain ☐I can stand for as long as I like but it gives me extra pain ☐Pain prevents me from standing for more than one hour ☐Pain prevents me from standing for more than 30 minutes ☐ Pain prevents me from standing for more than 10 minutes ☐Pain prevents me from standing at all

Section 7: Sleeping

☐My sleep is never disturbed ☐My sleep is occasionally disturbed by pain ☐Because of my pain I have less than 6 hours of sleep ☐ Because of my pain I have less than 4 hours of sleep ☐ Because of my pain I have less than 2 hours of sleep ☐Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

☐My sex life is normal and causes no extra pain ☐My sex life is normal but cause some extra pain ☐My sex life is nearly normal but is very painful ☐My sex life is severely restricted because of pain ☐My sex life is nearly absent because of pain ☐Pain prevents any sex life at all

Section 9: Social Life

☐My social life is normal and causes no extra pain ☐My social life is normal but cause some extra pain ☐Pain has no significant effect on my social life apart from limiting my energetic interests (e.g. sports) ☐Pain has restricted my social life and I do not go out as often ☐Pain has restricted my social life to home ☐I have no social life because of pain

Section 10: Traveling

☐I can travel anywhere without any pain ☐I can travel anywhere but it gives me extra pain ☐Pain is bad but I manage journeys over 2 hours ☐ Pain restricts me to journeys over 1 hour ☐Pain restricts me to short necessary journeys under 30 minutes ☐Pain prevents me from traveling except to receive treatment

Thank you for taking the time to fill out this MVA history questionnaire. This information is important in the doctor obtaining a clinical picture so as to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor at Neurological Rehabilitation Center LLC. Any disclosure is outlined in our privacy policies.

_____Patient's signature (*or guardian's signature*)

_____Signature of translator or person assisting with this form (*if any*)

Printed name of said person_____ _____Date