# Motor Vehicle Accident Information

<table>
<thead>
<tr>
<th>General Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Accident:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location (circle one)</th>
<th>Driver</th>
<th>Location (circle one)</th>
<th>Front / Middle / Rear</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Passenger</td>
<td>Position (circle one)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work from Left to Right and Circle One</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients Vehicle</strong></td>
</tr>
<tr>
<td><strong>Type</strong>: Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:</td>
</tr>
<tr>
<td><strong>Size</strong>: Mini / Sub Comp / compact / Mid Size / Full Size</td>
</tr>
<tr>
<td><strong>Action</strong>: Stopped / Slowing / Acceleration / Cruising</td>
</tr>
<tr>
<td><strong>Speed</strong>: (MPH)</td>
</tr>
<tr>
<td><strong>Time of Accident</strong>: Day Light / Dawn / Dusk / Dark</td>
</tr>
<tr>
<td><strong>Road Condition</strong>: Dry / Damp / Wet / Snow / Ice</td>
</tr>
<tr>
<td><strong>Visibility</strong>: Good / Fair / Poor</td>
</tr>
</tbody>
</table>

## Enter Impact Information for up to three Vehicles or Objects

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

(Select one)

- **Vehicle**
- **Object**

<table>
<thead>
<tr>
<th>Name Object :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle Type : Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:</td>
</tr>
<tr>
<td>Size : Mini / Sub Comp / compact / Mid Size / Full Size</td>
</tr>
<tr>
<td>Damage to Veh.: Minimal / Moderate / Extensive / Totaled / Unsure</td>
</tr>
</tbody>
</table>

### Impact Location

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

(Select one)

- **Vehicle**
- **Object**

<table>
<thead>
<tr>
<th>Name Object :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle Type : Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:</td>
</tr>
<tr>
<td>Size : Mini / Sub Comp / compact / Mid Size / Full Size</td>
</tr>
<tr>
<td>Damage to Veh.: Minimal / Moderate / Extensive / Totaled / Unsure</td>
</tr>
</tbody>
</table>

### Impact Location

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

(Select one)

- **Vehicle**
- **Object**

<table>
<thead>
<tr>
<th>Name Object :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle Type : Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:</td>
</tr>
<tr>
<td>Size : Mini / Sub Comp / compact / Mid Size / Full Size</td>
</tr>
<tr>
<td>Damage to Veh.: Minimal / Moderate / Extensive / Totaled / Unsure</td>
</tr>
</tbody>
</table>

### Impact Location
## During Impact Information:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seat Belt?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brakes Applied?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air Bag Deployed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seat Back position Changed?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Head Rest</td>
<td>Low / Mid / High / None</td>
<td></td>
</tr>
<tr>
<td>Prepare for Accident:</td>
<td>Un-expected / Expected / Expected and Braced</td>
<td></td>
</tr>
<tr>
<td>Body Position :</td>
<td>Straight / Rotated Left / Rotated Right / Unsure / Other:</td>
<td></td>
</tr>
<tr>
<td>Body Thrown?</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Direction of Throw:</td>
<td>Backwards / Forward / Outside / Unsure / Other:</td>
<td></td>
</tr>
</tbody>
</table>

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

- Head
- Upper Back
- Right hand
- Lower Back
- Left Shoulder
- Left Leg
- Mid Torso
- Right Foot
- Left Arm
- Right Leg
- Mid Back
- Right Knee
- Left Elbow
- Right Shoulder
- Left Knee
- Other:
- Left hand
- Right Arm
- Lower Front Torso
- Upper Front Torso
- Right Elbow
- Lower Front Torso

## After Accident Information:

### Immediately After Accident:
- Dizzy/dazed
- Upset
- Weak
- Nervous
- Headache
- Disoriented
- Unconscious
- Other:

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

- Head
- Left foot
- Right foot
- Left Knee
- Right Arm
- Left Shoulder
- Right Shoulder
- Left Arm
- Right knee
- Other:
- Upper Front Torso
- Mid Torso
- Right elbow
- Upper Back
- Mid Back
- Lower Front Torso
- Left Leg
- Right Leg
- Lower Back

### Numbness:
- Left Hand
- Right Hand
- Left Leg
- Right Leg
- Left Upper Arm
- Right Upper Arm
- Left Foot
- Right Foot
- Other:

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

- Medical Care? Yes 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? Yes No Days Spent in Hospital:
- Test: X-ray / Lab Work / MRI / CT Scan / Other:(Specify)
- Treatment: Ice Pack / Hot Pack / None / Cervical Collar / Medication / Other:(Specify)
### Previous Injuries

<table>
<thead>
<tr>
<th>Previous Injuries / Accidents</th>
<th>Yes, Specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residual pain from Previous Injuries/Accidents</td>
<td>Yes, Specify:</td>
</tr>
</tbody>
</table>

### Later Symptoms

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

<table>
<thead>
<tr>
<th>Head</th>
<th>Dizziness</th>
<th>Blurred Vision</th>
<th>Light Headedness</th>
<th>Loss of Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neck (with Movement)</th>
<th>Forward</th>
<th>Backward</th>
<th>Turn Left</th>
<th>Popping in Neck</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscle Spasms</td>
<td>Turn Right</td>
<td>Bend Left</td>
<td>Bend Right</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shoulders</th>
<th>Pain in Shoulder joint</th>
<th>Tension in shoulders</th>
<th>Muscle Spasms in Shoulder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Arms and Hands</th>
<th>Pain in Fingers</th>
<th>Numbness in Left Arm</th>
<th>Hands Cold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pin &amp; needles in hands</td>
<td>Numbness in Right Arm</td>
<td>Loss of Grip Strength</td>
<td></td>
</tr>
<tr>
<td>Pin &amp; needles in fingers</td>
<td>Swollen joints in fingers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chest</th>
<th>Pain Around Ribs</th>
<th>Shortness of Breadth</th>
<th>Breast Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abdomen</th>
<th>Nervous Stomach</th>
<th>Nausea</th>
<th>Diarrhea</th>
<th>Gas</th>
<th>Constipation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Specify:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mid back</th>
<th>Pain in Kidney Area</th>
<th>Pain From front to back</th>
<th>Dull Ache</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lower Back</th>
<th>Low Back Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low back pain is worse when</td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>Lifting</td>
</tr>
<tr>
<td>Sitting</td>
<td>Bending</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hips, Legs &amp; Feet</th>
<th>Pain in Buttocks</th>
<th>Pain and needles in Legs</th>
<th>Pain down leg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness in Toes</td>
<td>Feet feel Cold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg cramps</td>
<td>Numbness of Leg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cramps in Feet</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General</th>
<th>Nervousness</th>
<th>Fatigue</th>
<th>Irritable</th>
<th>Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally Feel Rundown</td>
<td>Prostate Pain/Swelling</td>
<td>Night Urination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty Urinating</td>
<td>Cramping</td>
<td>Irregularity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.