MVA INJURY HISTORY FORM

PATIENT INFORMATION Date _____

Patient's Name: _____
Patient's DOB: _____
Date of Accident: _____

GENERAL ACCIDENT INFORMATION

Was the accident on the job? ❑ Yes ❑ No
Type of collision: ❑ front impact ❑ rear impact
❑ right side ❑ left side ❑ other _____
Time of day: ❑ daylight ❑ dawn ❑ dusk
❑ dark _____ ❑ a.m. ❑ p.m.
Road condition: ❑ dry ❑ damp ❑ wet ❑ snow
❑ ice ❑ other _____
Weather conditions? ❑ clear ❑ other _____
Were police on-scene? ❑ Yes ❑ No
If yes, was a report made? ❑ Yes ❑ No
If yes, which department? _____

PATIENT VEHICLE INFORMATION

You were: ❑ driver ❑ front seat passenger
❑ rear seat passenger ❑ other _____
Vehicle driven by: _____
Was anyone else in the car? ❑ Yes ❑ No # _____
Vehicle year/make/model: _____
Vehicle transmission is: ❑ automatic ❑ manual
Estimated speed at time of accident: _____
❑ stopped ❑ slowing ❑ accelerating ❑ maintaining
Your car moved: ❑ a little ❑ more than a little
❑ a lot ❑ unknown
Head rest: ❑ none ❑ integrated ❑ adjustable
❑ above head ❑ below head
❑ behind head ❑ < 1 " ❑ 1 -2 " ❑ > 2 "
Was the seat altered/broken by accident: ❑ Yes ❑ No
Air bag deployed? ❑ Yes ❑ No ❑ Don't have one
If yes, were you struck? ❑ Yes ❑ No
Estimated property damage: ❑ unknown
❑ moderate ❑ major ❑ minimal

OTHER VEHICLE INFORMATION ❑ N/A

Compared to yours, the vehicle was: ❑ bigger
❑ smaller ❑ same size ❑ unsure
Vehicle year/make/model: _____
Collision speed was: ❑ high ❑ low ❑ unknown
Estimated property damage: ❑ unknown
❑ moderate ❑ major ❑ minimal

PATIENT DETAILED INFORMATION

Lap belt: ❑ wearing ❑ not wearing
Shoulder belt: ❑ wearing ❑ not wearing
Body position: _____
_____
Head position: ❑ neutral ❑ left _____°
❑ right _____° ❑ up _____° ❑ down _____°
Brakes applied? ❑ before impact ❑ after impact
❑ at the moment of impact ❑ _____
Aware of impending crash? ❑ Yes ❑ No
Did you strike any parts of the vehicle? ❑ Yes ❑ No
If yes, describe _____
Wearing: ❑ hat ❑ glasses ❑ N/A
If so, still on after crash? ❑ Yes ❑ No
Did you lose consciousness? ❑ Yes ❑ No
If yes, where did you wake up? _____
After the accident you went: ❑ emergency room
❑ home ❑ work ❑ other _____
Transport by: ❑ this car ❑ ambulance ❑ other car

ACCIDENT DESCRIPTION & DIAGRAM

_____
_____
_____
_____
_____
_____
_____
_____
_____

SYMPTOMS/ INJURIES AFTER COLLISION

❑ None of the following

❑ headache ❑ dizziness ❑ nausea ❑ weakness
❑ confusion/disorientation ❑ memory loss
❑ visual disturbances ❑ hearing disturbances
❑ numbness/tingling _____
❑ muscle spasms _____
❑ neck pain ❑ back pain ❑ jaw pain/dysfunction
❑ extremity pain _____
❑ radiating pain _____
❑ restriction of movement _____
❑ contusions _____
❑ lacerations _____
❑ fracture/dislocation _____
❑ other _____

EMERGENCY ROOM INFORMATION ❑ N/A

What hospital? _____
X-rays taken? ❑ Yes ❑ No
If yes, where? _____
Results: ❑ normal ❑ don't know ❑ fracture(s)
_____
Lab work done? ❑ Yes ❑ No
Stitches? ❑ Yes ❑ No
Other: _____
Medications: _____
_____
Follow-up instructions: ❑ Yes ❑ No
_____
Admitted to hospital (overnight): ❑ Yes ❑ No
If yes, how long: _____

PRE-EXISTING INJURY

Prior history of current complaints? ❑ Yes ❑ No
❑ resolved/stable ❑ unresolved/ongoing
Treated: ❑ < 24 months ago ❑ > 24 months ago
Last treatment date: ❑ N/A ❑ _____
Treated by: ❑ N/A ❑ _____
_____
_____

SLEEPING PROBLEMS SINCE ACCIDENT

Are you having difficulty getting to sleep? ❑ Y ❑ N
Are you unable get comfortable? ❑Y ❑N
Is pain waking you up at night? ❑ Y ❑ N
Do you toss and turn all night? ❑Y ❑ N
If you answered yes to any of the questions above, please explain _____

TREATMENT HISTORY ❑ N/A

1. _____
Initial DOS: _____
Referred By: _____
Currently Treating? ❑ Yes ❑ No
Special Tests: _____
Prescriptions: _____
Referred To: _____
Notes: _____
_____

2. _____
Initial DOS: _____
Referred By: _____
Currently Treating? ❑ Yes ❑ No
Special Tests: _____
Prescriptions: _____
Referred To: _____
Notes: _____
_____

NEUROMUSCULAR ORIGINAL COMPLAINTS

(applies if the accident is not recent) ❑ N/A

1. _____
Onset: _____
Refers/Radiates: _____
Severity (0-10): ____/❑ constant ❑ daily ❑ weekly

2. _____
Onset: _____
Refers/Radiates: _____
Severity (0-10): ____/❑ constant ❑ daily ❑ weekly

3. _____
Onset: _____
Refers/Radiates: _____
Severity (0-10): ____/❑ constant ❑ daily ❑ weekly

4. _____
Onset: _____
Refers/Radiates: _____
Severity (0-10): ____/❑ constant ❑ daily ❑ weekly

5. _____
Onset: _____
Refers/Radiates: _____
Severity (0-10): ____/❑ constant ❑ daily ❑ weekly

NEUROMUSCULAR CURRENT COMPLAINTS

1. _____
Location: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Refers/Radiates: _____
Severity (0-10): _____
Timing: ❑ constant ❑ off & on daily
❑ off & on during the week ❑ rarely
Temporal: ❑ a.m. ❑ daytime ❑ p.m. ❑ N/A

2. _____
Location: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Refers/Radiates: _____
Severity (0-10): _____
Timing: ❑ constant ❑ off & on daily
❑ off & on during the week ❑ rarely
Temporal: ❑ a.m. ❑ daytime ❑ p.m. ❑ N/A

3. _____
Location: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Refers/Radiates: _____
Severity (0-10): _____
Timing: ❑ constant ❑ off & on daily
❑ off & on during the week ❑ rarely
Temporal: ❑ a.m. ❑ daytime ❑ p.m. ❑ N/A

4. _____
Location: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Refers/Radiates: _____
Severity (0-10): _____
Timing: ❑ constant ❑ off & on daily
❑ off & on during the week ❑ rarely
Temporal: ❑ a.m. ❑ daytime ❑ p.m. ❑ N/A

NEUROMUSCULAR CURRENT COMPLAINTS
(continued)

5. _____
Location: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Refers/Radiates: _____
Severity (0-10): _____
Timing: ❑ constant ❑ off & on daily
❑ off & on during the week ❑ rarely
Temporal: ❑ a.m. ❑ daytime ❑ p.m. ❑ N/A

6. _____
Location: _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Refers/Radiates: _____
Severity (0-10): _____
Timing: ❑ constant ❑ off & on daily
❑ off & on during the week ❑ rarely
Temporal: ❑ a.m. ❑ daytime ❑ p.m. ❑ N/A

NON-NEUROMUSCULAR COMPLAINTS ❑ N/A

1. _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Refers/Radiates: _____
Severity (0-10): _____
Timing: ❑ constant ❑ off & on daily
❑ off & on during the week ❑ rarely
Temporal: ❑ a.m. ❑ daytime ❑ p.m. ❑ N/A

2. _____
Onset: _____
Provocative: _____
Palliative: _____
Quality: _____
Refers/Radiates: _____
Severity (0-10): _____
Timing: ❑ constant ❑ off & on daily
❑ off & on during the week ❑ rarely
Temporal: ❑ a.m. ❑ daytime ❑ p.m. ❑ N/A

Name _____

RECORDS REQUESTS ❑ N/A

❑ X-rays _____
❑ Medical Notes _____
❑ Ambulance _____

REFERRAL ❑ N/A

To: ❑ M.D./D.O. ❑ PT ❑ LMT ❑ Other

_____

ORDER TESTS ❑ N/A

❑ X-rays: _____
❑ CT/MRI: _____

NEUROMUSCULAR DIAGNOSES

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

NON-NEUROMUSCULAR DIAGNOSES ❑ N/A

1. _____
2. _____

ACTION TAKEN ON THIS VISIT

❑ Exam(s): ❑ C/S ❑ L/S ❑ Extremity

_____

❑ Treatment: _____

_____

❑ PT Exercises: ❑ C/S ❑ L/S ❑ Other

_____

❑ Cervical Pillow _____
❑ Work/School Restriction (see attached document)
❑ Supplements: _____
❑ Home Instructions: ❑ Ice ❑ Heat ❑ Biofreeze
❑ Other _____
❑ Treatment Plan: _____

_____

WORK INFORMATION ❑ N/A

What type of work do you do? _____

_____

Have you missed work because of this accident?
❑ Y ❑ N
If yes, list dates _____

_____

Will your employer allow light or restricted job duties?
❑ Y ❑ N
Do you feel you need assistance with household duties?
❑ Y ❑ N
If yes, explain _____

_____

SCHOOL INFORMATION ❑ N/A

Have you missed school because of this accident?
❑ Y ❑ N
If yes, list dates _____

_____

Do you participate in gym, sports or other activities?
❑ Y ❑ N
If yes, explain _____

_____

NOTES:

Name _____