

Motor Vehicle Accident (MVA) Intake

Note: If this is your first appt., please ALSO fill out a regular (non-MVA) intake form.

Name: _____ Today's Date: ____ / ____ / ____

Date of accident: ____ / ____ / ____ State where MVA occurred: _____

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger
 Pedestrian Bicyclist

Did your airbags inflate? Yes No

Were you wearing: Lap seatbelt Shoulder seatbelt Helmet

Did your car or bicycle impact another vehicle? Yes No

Did your car or bicycle impact a structure? Yes No

Was impact from: Front Back Left Right Other _____

Did any part of your body strike anything in the vehicle? Yes No

If yes, explain: _____

At the time of impact were you: Looking straight ahead Looking down

Looking up Looking to the left Looking to the right

Which hands were on the steering wheel? Both Right hand Left Hand

Which foot (if any) was on the brake? Left Foot Right Foot Neither

Were you: Surprised by impact Braced for impact

Have you received medical and/or therapeutic treatment as a result of your injury? Yes No

If yes, what type of care have you received (i.e. emergency, chiropractic, naturopathic, massage, etc.)? _____

Please turn over →

Please check any of the following symptoms that you have experienced since your injury:

- | | | |
|---|--|--|
| <input type="checkbox"/> Arm/ shoulder pain | <input type="checkbox"/> Feet/ toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/ finger numbness | <input type="checkbox"/> Neck stiffness |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nursing difficulty |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Confusion/ fogginess | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing/ ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vision blurred |

Please describe any other conditions resulting from your MVA that are not listed above: _____

Is this condition getting progressively worse? Yes No

If yes, please explain: _____

What activities or movements (i.e. sitting, standing, walking, bending, lying down, lifting) aggravate your symptoms? _____

Is there anything else you would like me to know about your MVA? _____

If you will be using automobile insurance to cover the cost of your treatment, please fill out the information below.

Insurance company: _____

Address where claims should be sent: _____

Phone number: _____

Claim number: _____

Thank you for your time!