Thank you for carefully answering each question!

***Patient:** Blue 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? _____

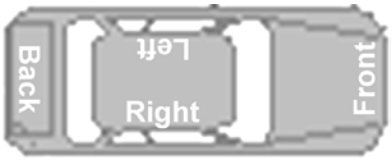
The Accident

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 rearview 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:_____

Doctor's Notes:_____

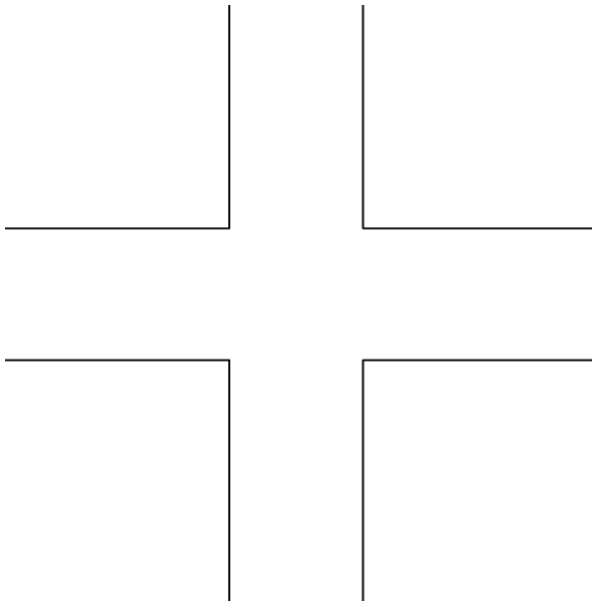
Doctor's Initials:_____

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

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:_____

_____.

Doctor's Notes:_____

_____

_____

Doctor's Initials:_____

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:_____.

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:_____
   _____.

Doctor's Notes:_____

_____

_____

Doctor's Initials:_____

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

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

Personal Care Activities:

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

Relationship Activities:

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

Child Care Activities:

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

Sports & Athletic Activities:

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

Social Activities:

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

Doctor's Notes:_____

Doctor's Initials:_____

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

General Household Activities:

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

Activities that Impact your Career:

- ☐ Attendance at work
- ☐ Performance at work
- ☐ Bending activities
- ☐ Bookkeeping
- ☐ Communication
- ☐ Concentration
- ☐ Data entry
- ☐ Driving
- ☐ Fine visual work
- ☐ Forceful exertion tasks
- ☐ Grasping actions
- ☐ Group tasks
- ☐ Heavy work
- ☐ Keyboarding
- ☐ Lifting objects
- ☐ Machine operation
- ☐ Memory
- ☐ Operating a mouse
- ☐ Prolonged sitting
- ☐ Prolonged standing
- ☐ Prolonged walking
- ☐ Perform required tasks
- ☐ Pushing actions
- ☐ Pulling actions
- ☐ Reaching actions
- ☐ Reading
- ☐ Repetitive motion
- ☐ Safety is affected
- ☐ Shoulder checking
- ☐ Speech
- ☐ Stairs
- ☐ Telephone operation
- ☐ Tool operation
- ☐ Transportation to work
- ☐ Writing
- ☐ Working on a computer
- ☐ Other:_____

_____

_____

General Movement Activities:

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

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 Applied Kinesiology Center of Clearwater t. Any disclosure is outlined in our privacy policies.

_____ Patient's signature (*or guardian's signature*)

_____ Date

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

Printed name of said person_____ _____ Date

Doctor's Notes:_____

_____

_____