Motor Vehicle Information Sheet

Name: ____________________________ My injury occurred on or around: ______________
Date

A Police Report was filled out: Yes ____ No ___ I don't know ___

I was 'At fault': Yes ___ No ___ I don't know ___

This is 'Contested'/being argued: Yes ___ No ___ I don't know ___

I was referred to this office by: ___________________________ ____________________
Name Number

This is the first time I saw a chiropractor/acupuncturist for this MVA: Yes ___ No ___

I am (*check all that apply*):
[] paying cash [] using my personal health insurance
[] using my own car insurance's 'Med Pay' (lien)
[] using the at fault person's car liability insurance (lien)
[] using my own attorney (lien)

Please fill out known fields:

Company Name: _________________________ Contact Name: _________________________

Contact Phone Number: __________________

Contact Fax Number: _____________________ Contact Email: ______________________________

Company Address: ____

Claim Number (*if applicable*): ___________________________________

Policy ID Number (*if applicable*): _______________________________ Group Number: _____________

I certify that to the best of my knowledge, the information in this form is true.

Signed: ____ Date: _____________________

Relationship to patient: _________________________

Advanced Laser Therapy and Wellness - PERSONAL INJURY QUESTIONNAIRE

NAME: ____ Date of accident________________

Where did accident happen? Describe the accident in your own words:

What was your position in the car?
☐ Driver: if driver, were your hands on the steering wheel? ☐ Left ☐ Right ☐ Both
☐ Passenger: if passenger, were you sitting in ☐ Front ☐ Right Rear ☐ Left Rear
Did your vehicle strike another vehicle ☐ Yes ☐ No
Was your vehicle struck by another vehicle ☐ Yes ☐ No
Angles of impact… First Collision: ☐ Front ☐ Back ☐ Left ☐ Right
If Second Collision: ☐ Front ☐ Back ☐ Left ☐ Right
Were you wearing a seat belt? ☐ Yes ☐ No
Did you brace for impact? ☐ Yes ☐ No … ☐ I braced with my hands ☐ I braced with my feet
Which way were you facing at the time of impact… ☐ straight ahead ☐ Left ☐ Right

Did you strike anything in vehicle at time of impact? ☐ Yes ☐ No
If yes, specify what part of your body struck what: ie… check box and write in body part that was struck
☐ Steering Wheel ________________________ ☐ Dashboard ___________________
☐ Windshield __________________________ ☐ Roof_________________________
☐ Left Side Door ______________________ ☐ Right Side Door___________________
☐ Left Side Window. ____________________ ☐ Right Window _______________________
☐ Other ____
Did the seat back bend / break ? ☐ Yes ☐ No

Immediately following the accident, how did you feel? ☐ dizzy/dazed ☐ disoriented ☐ unconscious
☐ nervous ☐ nauseous ☐ upset ☐ weak ☐ Other ____

Did you go to hospital ☐ Yes ☐ No Were you admitted to the hospital? ☐ Yes ☐ No if yes how long? ______
If you went to hospital, when? ☐ At time of accident ☐ Next day ☐ Other: ____________________
How did you get to hospital? ☐ Ambulance ☐ Police Car ☐ Private Transportation
Name of Hospital:____
Attended by Dr. ____
… what treatment was given?
☐ none ☐ placed in a cervical collar ☐ x-rayed ☐ CT/MRI ☐ given stitches
☐ given pain medication ☐ given instructions regarding concussions ☐ bandaged
☐ given instructions regarding sprains and strains ☐ Physical Therapy
☐ instructed to call a Orthopedic Surgeon ☐ instructed to call a private physician
☐ referred to this office for treatment ☐ Other ______________________________
____
Have you seen any other doctor as a result of this accident? ☐ Yes ☐ No
Doctor's name

CHIEF Complaints or Symptoms: **Name:** ______________________ **Date:** __________

☐ **Neck pain** check off the areas that the pain runs into from the neck	☐none ☐left shoulder ☐left arm ☐left forearm ☐left hand ☐right shoulder ☐right arm ☐right forearm ☐right hand
☐Headache	
☐Migraine Headache	
☐Upper back pain	

Ringing in Ears	☐Yes	☐No	☐Left	☐Right	☐Both Ears
Blurry Vision	☐Yes	☐No	☐Left	☐Right	☐Both Eyes
Wrist Pain	☐Yes	☐No	☐Left	☐Right	☐Both Wrists
Jaw Pain	☐Yes	☐No	☐Left	☐Right	☐Both Sides

☐dizziness ☐nervousness ☐fatigue ☐anxiety ☐depression ☐excessive irritability
☐fear of being in a car ☐loss of concentration ☐jaw clenching ☐grinding teeth at night ☐nightmares

☐ **Low Back Pain** select the areas of radiation, if any...	☐none ☐buttocks ☐left buttock ☐left thigh ☐left knee ☐left foot ☐right buttock ☐right thigh ☐right knee ☐right foot

Hip Pain	☐Left	☐Right	☐Bilateral
Knee Pain	☐Left	☐Right	☐Bilateral
Foot Pain	☐Left	☐Right	☐Bilateral

Numbness:

☐ Left Hand	☐Left Upper Arm	☐Right Hand	☐Right Upper Arm
☐ Left Foot	☐Left Leg	☐Right Foot	☐Right Leg

Additional Symptoms/ Complaints:

Have you had previous injuries or accidents? ☐Yes ☐ No
Description of previous Accident: ______________________
Description of previous injuries: ______________________
Is there any residual pain from the previous or old injury? ☐Yes ☐No
How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _________% better

Work Have You lost any time from work due to your injuries? ☐Yes ☐No
If yes please give dates: ______________________ Occupation: ______________

Sleep Are you having difficulty sleeping since the accident? ☐Yes ☐ No
If yes, how many hours of sleep are you losing per night? _________ Reason: ______________

Recreation Have you had to limit your recreational activities because of the accident? ☐Yes ☐ No
If yes, what limitations are you experiencing? Ie. can't work out, can't take walks, can't do a sport:

____

How much time lost: __________