Thank you for carefully answering each question!

Patient: Blue ink, Doctor: Red ink

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? _____

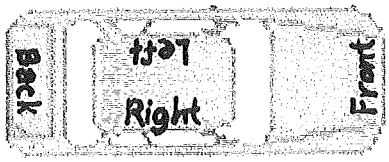
The Accident

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:_____

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

Doctor's Notes:_____

_____

_____

Doctor's Initials:_____

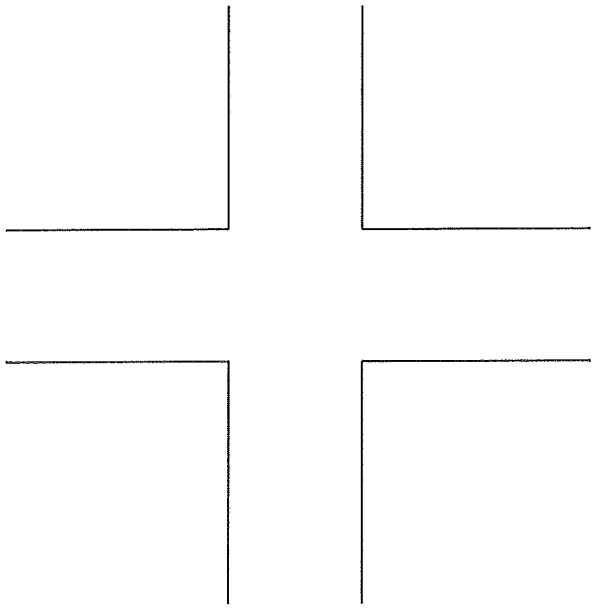
Thank you for carefully answering each question!

Patient: Blue ink, Doctor: Red ink

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:_____

_____.

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:_____.

Doctor's Notes:_____

_____

_____

Doctor's Initials:_____

Thank you for carefully answering each question!

Patient: Blue ink, Doctor: Red ink

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:_____

Thank you for carefully answering each question!

Patient: Blue ink, Doctor: Red ink

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

Personal Care Activities:

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

Relationship Activities:

Hugging	Laughing	Sexual activity	Other:
Kissing	Holding hands	Personal relationships	

Child Care Activities:

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

Sports & Athletic Activities:

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

Social Activities:

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

INSURANCE INFORMATION

INSURANCE COMPANY:	INSURANCE COMPANY PHONE:
ADJUSTER NAME:	ADJUSTER PHONE: Fax:
POLICY NUMBER:	CLAIM NUMBER:

Address:

Doctor's Notes:_____

_____

_____

Doctor's Initials:_____

Thank you for carefully answering each question!

Patient: Blue ink, Doctor: Red ink

Motor Vehicle Accident Health History Form (Page 5):

General Household Activities:

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

Activities that Impact your Career:

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

General Movement Activities:

Movements requiring neck strength or motion	Movements requiring upper back strength or motion
Movements requiring mid back strength or motion	Movements requiring lower back strength or motion
Movements requiring hand strength or motion	Movements requiring wrist strength or motion
Movements requiring elbow strength or motion	Movements requiring shoulder strength or motion
Movements requiring hip strength or motion	Movements requiring knee strength or motion
Movements requiring ankle 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 your doctor at Mountain View Pain Center LLC. 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)*_____ Date_____

Printed name of said person_____ Date_____

Doctor's Notes:_____

_____

_____

Doctor's Initials:_____