FULL POTENTIAL
CHIROPRACTIC

MVA Intake Form

Date: _____
Name: _____ Hm # _____ Cell #_____
Address: _____ Postal Code: _____
Birth Date: m ___d ___y_____ Sex: M / F
Date of Accident: _____ Time of Accident: _____
City of Accident: _____ Street of Accident: _____

Injury History:

1. What symptoms have you noticed since the accident: _____
_____
_____
_____

2. How long has this been going on? _____

3. What specific life activities does it interfere with (work, sleep, etc)? _____
_____

4. How frequent is the condition (constant, daily, etc)? _____

5. Is there anything you can do to relieve the problem? _____

6. What makes the problem worse? _____

7. Describe the pain: _____
Does it travel or radiate to other areas? _____

8. Are there other unrelated health problems? _____

9. Have you had any broken bones? _____

10. To your knowledge, have you had any diseases, major illnesses, or other injuries not indicated on this form either past or present? _____
_____

11. To your knowledge, is there a family history of cancer, stroke, diabetes, heart disease or a spinal condition? _____

12. List any medications you are taking: _____

Please place an "X" on the line below to indicate the level of the problem:

NO SYMPTOMS 0 ----------10 EXTREME SYMPTOMS

Your Accident Information:

Road conditions at the time of the accident: WET DRY ICY OTHER_____

Did the police come to the accident scene? YES NO: Is there a report? YES NO

Did you go to the hospital? YES NO
If yes, what is the name and city of the hospital? _____
How did you get to the hospital? _____
What parts of your body were x-rayed at the hospital? _____
What did the hospital do for your injuries? _____
How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____
What bruises did you sustain during this accident? _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?? AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO: How long? _____

Did you experience a flash of light or explosion in you head? YES NO

FULL POTENTIAL
CHIROPRACTIC

Did you become: CONFUSED DISORIENTED LIGHT HEADED DIZZY NAUSEATED
BLURRED VISION RING/BUZZ IN EARS
From the accident? (Please circle)

If you still have any of those symptoms, which ones? _____

Are you currently suffering for any of the following? (Please circle):
RESTLESSNESS IRRITABLE
DIFFICULTLY CONCENTRATING DIFFICULTY WITH MEMORY
SLEEPLESSNESS FORGETFULNESS
REDUCED TOLERANCE TO HEAT REDUCED TOLERANCE TO ALCOHOL
How far is the top of the headrest or seatback from the top of your head (approximately): _____ inches above or below?

Were you wearing a seatbelt? YES NO
If yes, was it a lap seatbelt_____ shoulder-lap seatbelt _____

List the year, make and model of the vehicle you were in:
Year _____ Make _____ Model _____

Was your car stopped at the time of impact? YES NO
If yes, was the driver's foot also on the brake? YES NO
If no, then estimate the speed of the vehicle you were in: _____km/hr

If your vehicle was moving at the time of impact, was it:
Slowing down? YES NO
Gaining speed? YES NO
Traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?
Head hit _____ Chest hit _____
Right/left shoulder hit_____ Right/left arm hit _____
Right/left hip hit _____ Right/left leg hit _____
Right/left knee hit _____ Other: _____

Did you receive any injury or bruise for the seat belt? YES NO
If YES, then describe: _____

What is the estimated cost damage to the vehicle you were in? $ _____

FULL POTENTIAL
CHIROPRACTIC

Which of the following car parts broke during the accident? (Please circle)

Windshield	Front seat back
Right/left side window	Other: _____
Steering wheel	Other: _____

Was the trunk of your body pointed straight forward at the time of the collision?
YES NO (If No) How was it turned? _____

What is the year, make and model of the **other** vehicle?
Year _____ Make _____ Model _____

Was the other vehicle moving at the time of the collision? YES NO
If yes, what was its approximate speed? _____ km/hr

If the other vehicle was moving at the time of the collision, was it (please circle):
Slowing down Gaining speed traveling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident:
_____