MVA: Accident Report Form

FULL NAME:	DATE OF ACCIDENT:
Date of FIRST VISIT in the office regarding this accident:	
Time of accident:	Place of accident:

Questionnaire

1. Were you using seat belts? Head rests?

2. Was your body thrown around? *Please specify which part of your body was struck and in which direction.*

3. Describe the sensation you felt:

Immediately after the impact

One hour later

That evening

MVA: Accident Report Form

The next day

4. Have you had other symptoms appear since the accident?

5. How long after the accident did they appear?

6. Were you taken to the hospital?

7. What other course of treatment(s) have you had with other doctors, physiotherapists, chiropractors, medication, x-rays, etc.?

8. What is your major complaint?

MVA: Accident Report Form

9. How long did it last?

10. Do you have any other symptoms? *(nausea, headache, etc.)*

11. How long did these last?

12. Did you experience any of the following?

Tingling of numbness in the extremities?

Dizziness?

Fatigue?

Other: _____

13. Describe the accident