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? _____

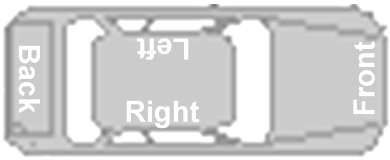
The Accident

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 your 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:_____

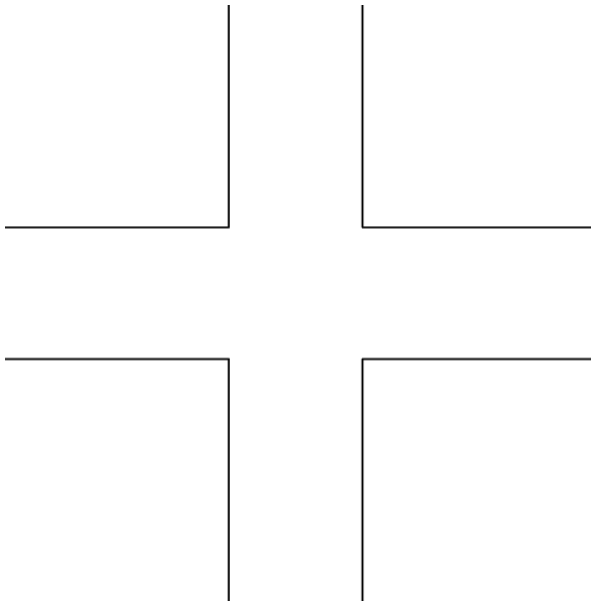
Doctor's Initials:_____

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 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 your doctor at Farkas Chiropractic Clinic. 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:_____

_____

_____