Natural Healing Arts Medical Center

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AUTO ACCIDENT QUESTIONAIRE-Please provide copy of Police Report

□ Auto Accident Date: _____ Time: _____(AM)(PM) Location: _____

Brief Description of the Accident: _____
_____

Patients vehicle (Yr, make, model) _____Ext speed _____MPH
Patients vehicle hit by _____ Ext speed _____MPH
Time: □ Day □ Night □ Dawn □ Dusk **Road Condition: □ Dry □ Damp □ Wet**
Did vehicle have seatbelts □ Yes □ No **Was seatbelt worn: □ Yes □ No**

Were You □ Driver □ Passenger Police Report: □ None □ Yes with Police Department
□ R Back seat □ L Back seat □ Front Middle □ Middle of Back

If vehicle had headrest, describe the position compared with top of your head:
□ Top of headrest aligned w/top of head □ Top of headrest aligned with the middle of the head
□ Top of headrest aligned w/bottom

Briefly describe the impact of collision: □ Head on collision □ L Side Impact □ R Side Impact □ Rear End
List any body parts that made contact with vehicle: _____

Hands: □ One on Wheel □ Two on Wheel **Were you braced for impact? □ Yes □ No**
Were Brakes Applied? □ Yes □ No **Were you looking into rear view mirror? □ Yes □ No**
Were you looking in the side mirrors? □ Yes □ No **Was your car stopped? □ Yes □ No**
Did you lose consciousness? □ Yes □ No **First Symptom appeared _____hr(s) after the MVA**
Wearing glasses? □ Yes □ No **Were they still on? □ Yes □ No**
Wearing hat? □ Yes □ No **Was it still on? □ Yes □ No**
Wearing dentures? □ Yes □ No **Were they still in? □ Yes □ No**
Estimated Property Damage? _____ □ Totaled □ Drivable □ Not Drivable
How many people in the car? _____Injured □ Yes □ No

Initial Symptoms: **□ None □ Headache □ Dizzy □ Disoriented □ Neck Pain**
□ Nausea □ Vomiting □ Blurred Vision □ Ringing in Ears □ Shock
□ Thoracic pain □ LBP/stiff □ Numbness/paresthesia

Did you go the hospital? □ Yes □ No Name of Hospital: _____
How did you go: □ Transported by Ambulance □ Drove yourself □ Someone drove you
When did you go: □ Immediately following mva □ Later-when _____
Were you admitted: □ Yes □ No How long did you stay: _____
Please indicate what was performed at hospital: □ X-Rays □ MRI □ CT □ Collar

Were you prescribed medications: □ Yes □ No List Name(s): _____
_____

Any previous motor vehicle accidents: □ Yes □ No Describe: _____
_____

If yes, was treatment previously rendered: □ Yes □ No Activities □ No Restrictions□ Missed_____ days work or school?
□ I had no symptoms prior to the accident

Patient Signature: _____Date:_____

Patient Representative: _____ Date: _____

Patient ID:_____