In this Report

Kinetic Health™
Soft Tissue Management Systems

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MVA – Accident Information

Note: Please be as accurate as possible, this information may form part of the bases of future medical legal reports.

Patient Name: _____

Date: _____

Patient Information:

___Male ___ Female Age _____ Weight ____ Height _____

Date of Accident:_____

Were **Police called** to the scene of the accident? **YES___ NO___**

If *YES*, what police department? _____

Describe the Accident:

Did you **go to the hospital** after the accident? **YES___ NO___**

If *YES*:

How soon after the accident?	How did you get to the hospital?	How did you leave the hospital?
___ within 1 hour ___ after 2-3 hours ___ after 4-8 hours ___ after 9-16 hours ___ after 17-24 hours ___ after 2 days ___ after 3 days ___ after 4-5 days ___ after 5-10 days ___ more than 10 days ___ Other	___ Ambulance ___ Your car ___ Someone else's car	_____ I drove home _____ Someone else drove

Were X-rays or other diagnostic procedures used at the hospital? **YES___ NO___**

If YES, what procedures were used and what were the results?

Did you receive treatment or medication at the hospital? **YES___ NO___**

If YES, what treatment or medication or advice was given at the hospital?

Have you seen any other practitioners about this accident (beside the hospital) before coming to our clinic? **YES___ NO___**

If YES, what examinations, treatment, diagnosis or advice have you been given?

What is the name and phone of these other practitioners who assisted you?

Vehicle Information

Patient Vehicle - check the correct options

What was the **make** of your car/truck?

_____

What was the **size** of your car/truck?

_____

How **far** did your car move after being struck?
_____ in/ft.

What was the approximate **speed** of your car at the time of the collision?
Standing still _____ 5 to 10 mph _____
10 to 15 mph _____ Other _____

If your vehicle was **standing still** at the time of the collision, did you have your foot or feet:
____ pressed on the brake?
____ resting on the brake?
____ off the brake?

What **direction** did the striking vehicle come from?
____ head-on
____ from behind
____ right side
____ left side

Did your vehicle **strike another vehicle** after the initial impact? **YES ____ NO ____**

What kind of **surface** were you driving on?
____ Dry pavement
____ Wet pavement
____ gravel
____ other _____

What direction was your car's **front tire** facing when your vehicle was struck?
____ Straight ahead
____ Right
____ Left

Was there any **damage** to your vehicle?
YES ____ NO ____

Were you the **driver**? **YES ___ NO ___**
If **NO**, where were you sitting?
____ front left ____ back left
____ front middle ____ back middle
____ front right ____ back right

Were you **wearing seat belts**? **YES** ___ **NO** ___
If *YES*, what kind?
____ shoulder only
____ lap only
____ combination of shoulder and lap

Did **air bags** deploy? **YES** ___ **NO** ___

Striking Vehicle - check the correct options

What was the **make** of the striking car/truck?

_____

What was the approximate **speed** of the striking vehicle at the time of the collision?
Standing still _____ 5 to 10 mph _____
10 to 15 mph _____ Other _____

What was the **size** of the striking car/truck?

_____

Was there any **damage** to the striking vehicle? **YES ____ NO ____**

If *YES*, what kind and degree of damage?

_____

Vehicular and Patient Relationship

Seat and Head Rest - check the correct options

Was the **seat** you were sitting in
_____ hard?
_____ soft?
_____ normal?

Did your seat have a **headrest**? **YES** ___ **NO** ___

If your seat had a headrest, how far away was the headrest in relationship to the **back of your head**?
_____ 0 to 1 inch
_____ 1 to 2 inches
_____ 2 to 3 inches
_____ Estimated distance

If your seat had a headrest, where was the top of the headrest in **relationship** to the **top of your head**?

_____ The top of the headrest came **below** the top of my head by _____ inches.
_____ The top of the headrest was **even** with my head.
_____ The top of the headrest was **above** my head by _____inches.

Facts about the Patient *during* this MVA Accident

Check the appropriate options

Did you **realize** that your car was going to be hit by the other car?
YES _____ **NO** _____

If *YES*, did you brace your arms and legs?
YES _____ **NO** _____

When your car was struck, **what direction** were you looking?
_____Straight ahead
_____Looking up
_____Looking down
_____To the right
_____To the left

If your head **was turned**, estimate the degrees it was turned to the:
_____Right
_____Left

If your head **was looking** up or down, estimate the degrees:

_____up

_____down

Did your head strike any objects during the impact (for example: window, steering wheel, etc)
YES _____ **NO** _____

If *YES*, provide details:

Did you lose consciousness after impact?
YES _____ **NO** _____

Did you experience any of the following after the accident?
_____ Confusion
_____ Severe headache
_____ Nausea or Vomiting
_____ Blurred Vision
_____ Loss of Short Term Memory
_____ Trouble understanding conversations
_____Extreme drowsiness

Facts Concerning the Patient *after* the MVA Accident

What do you **remember immediately after** the accident?

Since the accident have you noticed any of the following symptoms?

1. Headaches. **YES ___ NO ___**
2. Light-headedness. **YES ___ NO ___**
3. Dizziness or spinning sensation. **YES ___ NO ___**
4. Poor concentration. **YES ___ NO ___**
5. Nausea or vomiting. **YES ___ NO ___**
6. Lack of awareness of surroundings. **YES ___ NO ___**
7. Irritability, feeling frustrated. **YES ___ NO ___**
8. Easily tired. **YES ___ NO ___**
9. Problems sleeping. **YES ___ NO ___**
10. Intolerance of loud noises. **YES ___ NO ___**
11. Ringing in the ears. **YES ___ NO ___**
12. Intolerance bright lights. **YES ___ NO ___**
13. Feeling anxious. **YES ___ NO ___**
14. Feeling depressed. **YES ___ NO ___**
15. Crying for no apparent reason. **YES ___ NO ___**
16. Memory problems. **YES ___ NO ___**

Previous History of MVA Accidents

Have you ever been in a previous motor vehicle accident? **YES** ___ **NO** ___

Patient Signature: _____

If YES please provide all information about prior accidents if NO proceed to next section.

Date and location of previous MVA:

1. Injuries sustained during prior accident (MVA):

2. Name of practitioners who provided treatments for prior accident if known:

3. Were all symptoms from this prior accident resolved before your most recent accident? **YES** ___ **NO** ___

    - If NO, what symptoms of this prior accident persisted?

    - If No did these symptoms affect your function (ability to perform tasks) in any way prior to this most recent accident? **YES** ___ **NO** ____

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    - If No did these symptoms affect your function (ability to perform tasks) in any way prior to this most recent accident? **YES** ___ **NO** ____

Date and location of previous MVA:

1. Injuries sustained during prior accident (MVA):

2. Name of practitioners who provided treatments for prior accident if known:

3. Were all symptoms from this prior accident resolved before your most recent accident? **YES** ___ **NO** ___

    - If NO, what symptoms of this prior accident persisted?

    - If No did these symptoms affect your function (ability to perform tasks) in any way prior to this most recent accident? **YES** ___ **NO** ____

Symptoms and Conditions *After* this MVA Accident

Describe all the symptoms and conditions from which you suffered **after the current MVA accident**. Describe the **physical problems** that you have. Use additional pages if necessary

Symptom/Condition - *After the Accident*	Symptom/Condition - *After the Accident*
Name of symptom:_____ **When** did this problem start? _____ What makes this **problem better or worse**? Describe what this **problem feels** like: Does this **pain** stay one place or radiate to other areas of your body? What **time of day** is this symptom worse, and how frequently does this symptom occur? **Who** has treated you for this symptom? What **types of treatment** have you received for this condition?	**Name** of symptom:_____ **When** did this problem start? _____ What makes this **problem better or worse**? Describe what this **problem feels** like: Does this **pain** stay one place or radiate to other areas of your body? What **time of day** is this symptom worse, and how frequently does this symptom occur? **Who** has treated you for this symptom? What **types of treatment** have you received for this condition?
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MVA Impacts on Your Lifestyle

Check the activities that have been **affected adversely**, or that **are difficult to perform**, since you had your MVA Accident.

Domestic

- check the affected options

___ Cleaning
___ Cooking
___ Eating
___ Folding Laundry
___ Getting Into or Out of Bed
___ Holding Bowls, Cups, etc.
___ Moving Items
___ Lifting
___ Sitting
___ Sleeping
___ Standing
___ Vacuuming
___ Other Domestic Activity

Personal Care

- check the affected options

___ Applying Makeup
___ Bathing
___ Brushing Teeth
___ Combing Hair
___ Flossing
___ Dressing
___ Nail Care
___ Shampooing
___ Gargling
___ Showering
___ Toilet Care
___ Shaving

Interpersonal Behaviors

- check the affected options

___ Hugging
___ Kissing
___ Sexual Activity
___ Personal Relationships
___ Other Interpersonal Activity

Working with Children

- check the affected options

___ Bathing
___ Breast/Bottle Feeding
___ Carrying Kids
___ Changing Diapers
___ Entertaining
___ Packing Lunches
___ Picking Up/Hugging
___ Picking Up Toys
___ Playing
___ Pushing Strollers
___ Toweling After Bath
___ Washing/Shampooing
___ Rocking
___ Other Child Care Activity

Sports and Entertainment

- check the sports or activates adversely affected**, or that** are difficult to perform since the MVA.

___ Aerobics
___ Archery
___ ATV Riding
___ Baseball
___ Badminton
___ Basketball
___ Biking
___ Boogie Boarding
___ Bowling
___ Camping
___ Canoeing
___ Cross Country Skiing
___ Down Hill Skiing
___ Football
___ Golf
___ Gymnastics
___ Rock Climbing
___ Handball
___ Horse Back Riding
___ Hunting
___ Ice Skating
___ Jet Skiing
___ Martial Arts
___ Paddle Ball
___ Soccer
___ Softball
___ Snowmobiling
___ Snow Boarding
___ Surfing
___ Swimming
___ Table Tennis
___ Racquet sports
___ Rafting
___ Rollerblading
___ Roller Skating
___ Rugby
___ Running/Jogging
___ Tennis
___ Walking
___ Weight Training
___ Wind Surfing
___ Working out
___ Wrestling
___ Volleyball
___ Yoga
___ Other Sport and Entertainment Activity

Social Activities

- check the affected options

___ Religious Practices
___ Concerts, Music
___ Dancing
___ Eating Out
___ Entertaining
___ Going Out
___ Movies
___ Picnics
___ Reading
___ Shopping
___ Sightseeing
___ Vacations
___ Visiting
___ Walking
___ Other Social Activities

Out of the House – Household Activities

- check the affected options

___ Car Maintenance
___ Cleaning Gutters
___ Cleaning Interior Car
___ Cleaning Pool
___ Clearing Brush
___ Fertilizing
___ Hammering
___ Mowing Grass
___ Painting
___ Pruning
___ Raking
___ Scraping Walls
___ Shoveling Driveway
___ Spraying
___ Taking Out Trash
___ Tree Trimming
___ Using Tools
___ Walking Dog
___ Washing Car
___ Watering Lawn
___ Weeding
___ Yard Work
___ Other Out of House Activity

Impacts on Your Career

- check the affected tasks, activities or motions.

___ Activities requiring **Hand** strength or motion.
___ Activities requiring **Wrist** strength or motion.
___ Activities requiring **Elbow** strength or motion.
___ Activities requiring **Shoulder** strength or motion.
___ Activities requiring **Neck** strength or motion.
___ Activities requiring **Upper Back** strength or motion.
___ Activities requiring **Mid Back** strength or motion.
___ Activities requiring **Low Back** strength or motion.
___ Activities requiring **Hip** strength or motion.
___ Activities requiring **Leg** strength or motion.
___ Activities requiring **Knee** strength or motion.
___ Activities requiring **Ankle** strength or motion.
___ Activities requiring **Foot** strength or motion.
___ Attendance 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
___ Lifting people
___ Writing
___ Machine operation
___ Maintaining static position
___ Memory
___ Performing required tasks
___ Physically demanding tasks
___ Precision tasks
___ Pulling actions
___ Pushing actions
___ Reaching actions
___ Reading
___ Repetitive motion activities
___ Safety is affected
___ Shoulder checking
___ Sitting for periods of time
___ Speech
___ Stairs
___ Standing for periods of time
___ Telephone
___ Tool operation
___ Transportation to work
___ Using a mouse
___ Walking for period of time
___ Working on computers
___ Other Activities: please note in space below.

Notes: