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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:

Kinetic Health™

Soft Tissue Management Systems

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Bay # 10, 34 Edgedale Drive NW.
Calgary, Alberta, Canada, T3A-2R4
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www.drabelson.com
www.activerelease.com
www.releaseyourbody.com



Motor Vehicle Accident Report – Information and History

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?
<input type="checkbox"/> within 1 hour <input type="checkbox"/> after 2-3 hours <input type="checkbox"/> after 4-8 hours <input type="checkbox"/> after 9-16 hours <input type="checkbox"/> after 17-24 hours <input type="checkbox"/> after 2 days <input type="checkbox"/> after 3 days <input type="checkbox"/> after 4-5 days <input type="checkbox"/> after 5-10 days <input type="checkbox"/> more than 10 days <input type="checkbox"/> Other	<input type="checkbox"/> Ambulance <input type="checkbox"/> Your car <input type="checkbox"/> Someone else's car	<input type="checkbox"/> I drove home <input type="checkbox"/> 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 **size** 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 _____

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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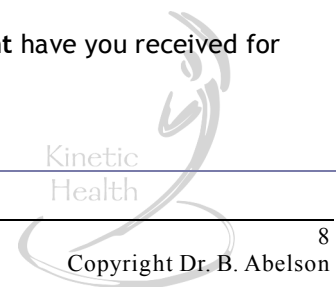
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Symptoms and Conditions *After* this MVA Accident

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

<i>Symptom/Condition - After the Accident</i>	<i>Symptom/Condition - After the Accident</i>
<p>Name of symptom: _____</p> <p>When did this problem start? _____</p> <p>What makes this problem better or worse?</p> <p>Describe what this problem feels like:</p> <p>Does this pain stay one place or radiate to other areas of your body?</p> <p>What time of day is this symptom worse, and how frequently does this symptom occur?</p> <p>Who has treated you for this symptom?</p> <p>What types of treatment have you received for this condition?</p>	<p>Name of symptom: _____</p> <p>When did this problem start? _____</p> <p>What makes this problem better or worse?</p> <p>Describe what this problem feels like:</p> <p>Does this pain stay one place or radiate to other areas of your body?</p> <p>What time of day is this symptom worse, and how frequently does this symptom occur?</p> <p>Who has treated you for this symptom?</p> <p>What types of treatment have you received for this condition?</p>
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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		
<input type="checkbox"/> Cleaning	<input type="checkbox"/> Holding Bowls, Cups, etc.	<input type="checkbox"/> Standing
<input type="checkbox"/> Cooking	<input type="checkbox"/> Moving Items	<input type="checkbox"/> Vacuuming
<input type="checkbox"/> Eating	<input type="checkbox"/> Lifting	<input type="checkbox"/> Other Domestic Activity
<input type="checkbox"/> Folding Laundry	<input type="checkbox"/> Sitting	
<input type="checkbox"/> Getting Into or Out of Bed	<input type="checkbox"/> Sleeping	
Personal Care		
- check the affected options		
<input type="checkbox"/> Applying Makeup	<input type="checkbox"/> Bathing	<input type="checkbox"/> Brushing Teeth
<input type="checkbox"/> Combing Hair	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dressing
<input type="checkbox"/> Nail Care	<input type="checkbox"/> Shampooing	<input type="checkbox"/> Gargling
<input type="checkbox"/> Showering	<input type="checkbox"/> Toilet Care	<input type="checkbox"/> Shaving
Interpersonal Behaviors		
- check the affected options		
<input type="checkbox"/> Hugging	<input type="checkbox"/> Sexual Activity	<input type="checkbox"/> Other Interpersonal Activity
<input type="checkbox"/> Kissing	<input type="checkbox"/> Personal Relationships	
Working with Children		
- check the affected options		
<input type="checkbox"/> Bathing	<input type="checkbox"/> Packing Lunches	<input type="checkbox"/> Toweling After Bath
<input type="checkbox"/> Breast/Bottle Feeding	<input type="checkbox"/> Picking Up/Hugging	<input type="checkbox"/> Washing/Shampooing
<input type="checkbox"/> Carrying Kids	<input type="checkbox"/> Picking Up Toys	<input type="checkbox"/> Rocking
<input type="checkbox"/> Changing Diapers	<input type="checkbox"/> Playing	<input type="checkbox"/> Other Child Care Activity
<input type="checkbox"/> Entertaining	<input type="checkbox"/> Pushing Strollers	
Sports and Entertainment		
- check the sports or activates adversely affected, or that are difficult to perform since the MVA.		
<input type="checkbox"/> Aerobics	<input type="checkbox"/> Handball	<input type="checkbox"/> Rollerblading
<input type="checkbox"/> Archery	<input type="checkbox"/> Horse Back Riding	<input type="checkbox"/> Roller Skating
<input type="checkbox"/> ATV Riding	<input type="checkbox"/> Hunting	<input type="checkbox"/> Rugby
<input type="checkbox"/> Baseball	<input type="checkbox"/> Ice Skating	<input type="checkbox"/> Running/Jogging
<input type="checkbox"/> Badminton	<input type="checkbox"/> Jet Skiing	<input type="checkbox"/> Tennis
<input type="checkbox"/> Basketball	<input type="checkbox"/> Martial Arts	<input type="checkbox"/> Walking
<input type="checkbox"/> Biking	<input type="checkbox"/> Paddle Ball	<input type="checkbox"/> Weight Training
<input type="checkbox"/> Boogie Boarding	<input type="checkbox"/> Soccer	<input type="checkbox"/> Wind Surfing
<input type="checkbox"/> Bowling	<input type="checkbox"/> Softball	<input type="checkbox"/> Working out
<input type="checkbox"/> Camping	<input type="checkbox"/> Snowmobiling	<input type="checkbox"/> Wrestling
<input type="checkbox"/> Canoeing	<input type="checkbox"/> Snow Boarding	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Cross Country Skiing	<input type="checkbox"/> Surfing	<input type="checkbox"/> Yoga
<input type="checkbox"/> Down Hill Skiing	<input type="checkbox"/> Swimming	<input type="checkbox"/> Other Sport and Entertainment Activity
<input type="checkbox"/> Football	<input type="checkbox"/> Table Tennis	
<input type="checkbox"/> Golf	<input type="checkbox"/> Racquet sports	
<input type="checkbox"/> Gymnastics	<input type="checkbox"/> Rafting	
<input type="checkbox"/> Rock Climbing		

Motor Vehicle Accident Report – Information and History

Social Activities

- check the affected options

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Religious Practices | <input type="checkbox"/> Going Out | <input type="checkbox"/> Sightseeing |
| <input type="checkbox"/> Concerts, Music | <input type="checkbox"/> Movies | <input type="checkbox"/> Vacations |
| <input type="checkbox"/> Dancing | <input type="checkbox"/> Picnics | <input type="checkbox"/> Visiting |
| <input type="checkbox"/> Eating Out | <input type="checkbox"/> Reading | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Entertaining | <input type="checkbox"/> Shopping | <input type="checkbox"/> Other Social Activities |

Out of the House – Household Activities

- check the affected options

- | | | |
|--|---|--|
| <input type="checkbox"/> Car Maintenance | <input type="checkbox"/> Painting | <input type="checkbox"/> Using Tools |
| <input type="checkbox"/> Cleaning Gutters | <input type="checkbox"/> Pruning | <input type="checkbox"/> Walking Dog |
| <input type="checkbox"/> Cleaning Interior Car | <input type="checkbox"/> Raking | <input type="checkbox"/> Washing Car |
| <input type="checkbox"/> Cleaning Pool | <input type="checkbox"/> Scraping Walls | <input type="checkbox"/> Watering Lawn |
| <input type="checkbox"/> Clearing Brush | <input type="checkbox"/> Shoveling Driveway | <input type="checkbox"/> Weeding |
| <input type="checkbox"/> Fertilizing | <input type="checkbox"/> Spraying | <input type="checkbox"/> Yard Work |
| <input type="checkbox"/> Hammering | <input type="checkbox"/> Taking Out Trash | <input type="checkbox"/> Other Out of House Activity |
| <input type="checkbox"/> Mowing Grass | <input type="checkbox"/> Tree Trimming | |

Impacts on Your Career

- check the affected tasks, activities or motions.

- | | | |
|---|---|--|
| <input type="checkbox"/> Activities requiring Hand strength or motion. | <input type="checkbox"/> Attendance at work | <input type="checkbox"/> Safety is affected |
| <input type="checkbox"/> Activities requiring Wrist strength or motion. | <input type="checkbox"/> Bending activities | <input type="checkbox"/> Shoulder checking |
| <input type="checkbox"/> Activities requiring Elbow strength or motion. | <input type="checkbox"/> Bookkeeping | <input type="checkbox"/> Sitting for periods of time |
| <input type="checkbox"/> Activities requiring Shoulder strength or motion. | <input type="checkbox"/> Communication | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Activities requiring Neck strength or motion. | <input type="checkbox"/> Concentration | <input type="checkbox"/> Stairs |
| <input type="checkbox"/> Activities requiring Upper Back strength or motion. | <input type="checkbox"/> Data entry | <input type="checkbox"/> Standing for periods of time |
| <input type="checkbox"/> Activities requiring Mid Back strength or motion. | <input type="checkbox"/> Driving | <input type="checkbox"/> Telephone |
| <input type="checkbox"/> Activities requiring Low Back strength or motion. | <input type="checkbox"/> Fine visual work | <input type="checkbox"/> Tool operation |
| <input type="checkbox"/> Activities requiring Hip strength or motion. | <input type="checkbox"/> Forceful exertion tasks | <input type="checkbox"/> Transportation to work |
| <input type="checkbox"/> Activities requiring Leg strength or motion. | <input type="checkbox"/> Grasping actions | <input type="checkbox"/> Using a mouse |
| <input type="checkbox"/> Activities requiring Knee strength or motion. | <input type="checkbox"/> Group tasks | <input type="checkbox"/> Walking for period of time |
| <input type="checkbox"/> Activities requiring Ankle strength or motion. | <input type="checkbox"/> Heavy work | <input type="checkbox"/> Working on computers |
| <input type="checkbox"/> Activities requiring Foot strength or motion. | <input type="checkbox"/> Keyboarding | <input type="checkbox"/> Other Activities: please note in space below. |
| | <input type="checkbox"/> Lifting objects | |
| | <input type="checkbox"/> Lifting people | |
| | <input type="checkbox"/> Writing | |
| | <input type="checkbox"/> Machine operation | |
| | <input type="checkbox"/> Maintaining static position | |
| | <input type="checkbox"/> Memory | |
| | <input type="checkbox"/> Performing required tasks | |
| | <input type="checkbox"/> Physically demanding tasks | |
| | <input type="checkbox"/> Precision tasks | |
| | <input type="checkbox"/> Pulling actions | |
| | <input type="checkbox"/> Pushing actions | |
| | <input type="checkbox"/> Reaching actions | |
| | <input type="checkbox"/> Reading | |
| | <input type="checkbox"/> Repetitive motion activities | |

Notes:

