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MVA HISTORY FORM

NAME: _____ DOB: _____ AGE: _____ SEX: M F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL #: _____ SSN: _____ STATUS: M W D S

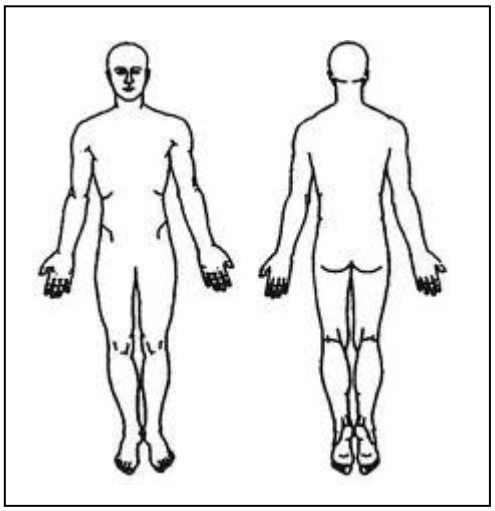
HOME PHONE #: _____ WORK #: _____ EMAIL: _____

HEIGHT: _____ WEIGHT: _____ SHOE SIZE: _____ CHILDREN (How many): _____

OCCUPATION: _____ EMPLOYER: _____

DATE OF ACCIDENT: TIME ACCIDENT OCCURRED: _____

PLEASE DESCRIBE WHAT HAPPENED: _____



On The Pain Drawing above please place a circle on each area where you experience symptoms. Make sure to include all areas.

HOW BAD IS YOUR PAIN? (Please Circle a Number)

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

HOW OFTEN ARE YOUR SYMPTOMS PRESENT? ❑ 0 to 25% ❑ 26 to 50% ❑ 51 to 75% ❑ 76 to 100%

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. This will help us better understand you injuries.

Road conditions at the time of the accident ❑ wet ❑ dry ❑ icy ❑ other: _____

Did the police come to the accident scene? ❑ Yes ❑ no

Is there a police report? ❑ Yes ❑ no

Was your car stopped during the impact? ❑ Yes ❑ no

If yes, was the driver's foot on the break? ❑ Yes ❑ no

If no, estimate how fast you were traveling: _____ mph

Did you go to the hospital? Date _____ ❑ Yes ❑ no If yes, how did you get there?

If yes, Name of the Hospital _____ ❑ ambulance ❑ private vehicle

What treatment was rendered for this injury? ❑ Examination ❑ x-ray ❑ CAT Scan ❑ MRI ❑ medication ❑ physical therapy

If x-rayed, MRI or CAT Scan, what body parts were examined? _____

Were any other Health Care Providers seen for this injury? ❑ Yes ❑ no If yes, please list them plus treatment received: _____

Where were you seated in the vehicle during the accident? ❑ Driver ❑ Passenger front ❑ Passenger's side rear ❑ Driver's side rear

During the accident my **HEAD** was: ❑ Straight ahead ❑ Turned to the right ❑ Turned to the left ❑ Inclined forward

During the accident my **BODY** was: ❑ Straight ahead ❑ Turned to the right ❑ Turned to the left ❑ Inclined forward

Were you aware or surprised by the approaching collision prior to impact? ❑ Aware ❑ Surprised

When did your pain start? ❑ Immediately after the impact ❑ Later that day ❑ Next day ❑ Other (when): _____

Patient's Name: _____ Date: _____

List the year, make and model of the vehicle you were in during the accident. (Example 2009 Ford Explorer):

Year: _____ Make: _____ Model: _____

How fast was your vehicle traveling? MPH. How fast was the other vehicle traveling? MPH.

List the year, make and model of the other vehicle. (Example: 2009 Ford Explorer):

Year: _____ Make: _____ Model: _____

What is the estimated cost of damage to the vehicle you were in? $_____

During the accident were you wearing a: ❑ lap seatbelt ❑ shoulder-lap seatbelt

Did you receive any injuries or bruising from the seatbelt? ❑ Yes ❑ No; If yes, location: _____

Did you lose consciousness (black out) upon impact? ❑ Yes ❑ No; If yes, how long: _____

Did you experience a flash of light or explosion in your head during impact? ❑ Yes ❑ No

Did you become: ❑ Dizzy ❑ Confused ❑ Disoriented ❑ Light-headed

❑ Nauseated ❑ Experience blurred vision ❑ Experience a ringing or buzzing in your ears

Since the accident which of the following symptoms are you experiencing? ❑ Sleeplessness ❑ Pain related loss of sleep

❑ Reduced tolerance to heat ❑ Irritability ❑ Forgetfulness ❑ light headedness ❑ Difficulty with memory

❑ Blurred vision ❑ Restlessness ❑ Buzzing in ears ❑ Ringing in ears ❑ Reduced tolerance to alcohol

❑ Difficulty concentrating ❑ Emotional ❑ Difficulty falling asleep ❑ Difficulty staying asleep

Did you miss work due to this injury? ❑ Yes ❑ No. If yes, please list: _____

PLEASE CHECK ALL THE FOLLOWING THAT APPLIES TO YOU: **❑ NONE APPLY**

❑ Recent infection: _____ ❑ Recent fever ❑ HIV/AIDS

❑ Diabetes: Medication (Rx): _____ ❑ Corticosteroid use ❑ Birth control pills

❑ High blood pressure: (Rx): _____ ❑ Stroke: Date: _____ ❑ Dizziness/fainting

❑ Numbness / pain in groin / buttocks ❑ Urinary retention ❑ Osteoporosis

❑ Aortic aneurism: Date: _____ ❑ Cancer / Tumor: Date: _____ ❑ Prostate problems

❑ Thyroid: (Rx): _____ ❑ Recent trauma: Date: _____ ❑ Frequent urination

❑ Are you pregnant: ❑ Yes ❑ No ❑ N/A. If yes, due date: _____ ❑ Epilepsy / seizures

❑ If male, do you have children at home? ❑ Yes ❑ No. If yes, how many: _____ ❑ Arthritis

❑ If female, How many pregnancies: _____ Births: _____ C-sections: _____ ❑ Visual disturbances

❑ Abnormal weight: ❑ gain ❑ loss ❑ History of low back pain ❑ Yes ❑ No. If yes, when: _____

❑ History of neck pain ❑ Yes ❑ No. If yes, when: _____ ❑ History of tobacco use ❑ History of alcohol use

❑ Surgeries ❑ Yes ❑ No. If yes, location / when: _____

Please list any medications you are taking both prescription and over the counter which are not listed above: _____

_____

Family History: ❑ Cancer ❑ Diabetes ❑ High blood pressure ❑ Cardiovascular (heart attack, stroke, etc).

I certify the above information is complete and accurate to the best of my knowledge. I agree to notify Dr. Tereo and his staff whenever I have changed his in my health condition in the future or of any changes my mailing address or phone number.

PATIENT'S SIGNATURE: _____ DATE: _____